FOR STATE HEALTH DEPT.

with the State Board

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07747

7762 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

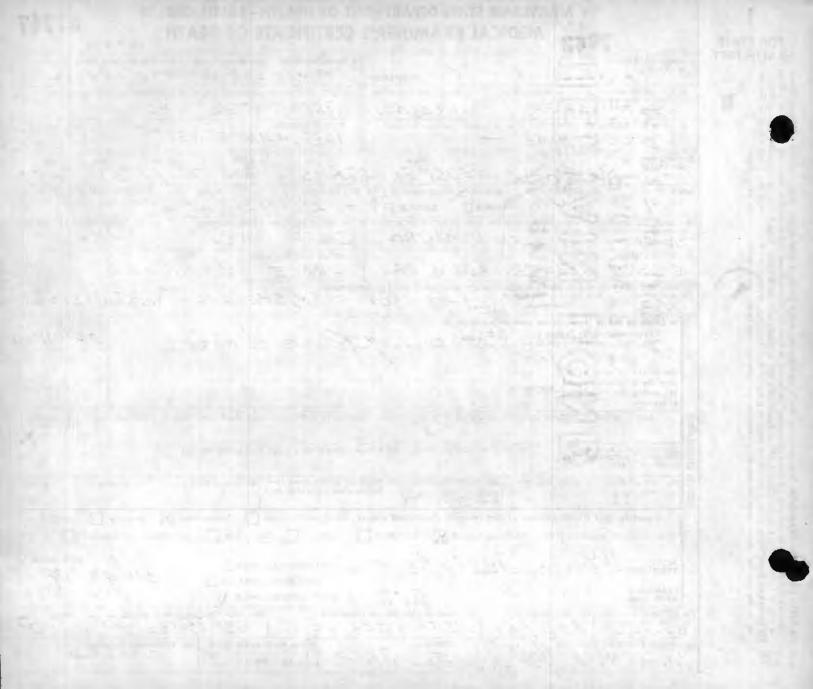
| 1. PLACE OF DEATH O. COUNTY AIRROLL COUNTY | 7- MARYLAND | 2. USUAL RESIDENCE (WHO O. STATE MARKE | nere deceased lived. If institution b. COUNTY | on: Residence before admission) CARROLL |
|--|----------------------------|--|---|--|
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give neotest foun) WESTMUSTER | c. LENGTH OF STAY IN 16 | WESTMIN | outside corporate limits, write RI | URAL and give nearest lown) |
| d. NAME OF HOSPITAL OR INSTITUTION (IF not in hosp | ital, give street address) | d. STREET ADDRESS 2188 MAI | N STREET | e. IS RESIDENCE ON A FARM? YES NO |
| 3. NAME OF DECEASED (Type or print) MATTHEW W | Middle EBSTER | ADAMS 4 | DATE Month OF DEATH | 3 / Yeor 1959 |
| 5. SEX 6. COLOR OR RACE 7. MARRIED WIDOWED | | DAYE OF BIRTH 4/2/191 | Book brook do b | FUNDER TYEAR IF UNDER 24 HRS. Months Doys Hours Min. |
| 100. USUAL OCCUPATION (Give kind of work done 10b. Kind during most of working life, even if refired) | ND OF BUSINESS OR INDUST | 570 4 | r foreign country) MD, | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME EDWIN WEBSTER A. | DAMS SR, | GRACE | BURKA | HART |
| (You an as unknown) a fill one wine over as detay of constant | 18 -07-58 08 | FORMANT DR. SF | PEICHER - W | ESTHINSTER |
| Conditions, if ony, which gove rise to immediate couse (a), stating the underlying couse lost. | rowary | 1-moin | pass) | ONSE AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS COL | NTRIBUTING TO DEATH BUT N | OT RELATED TO THE TERMIN | ALDISEASE CONDITION GIVEN | N IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO |
| 200. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. | HOW INJURY OCCURRED (E | nter noture of injury in Part I | or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year 20d. IN Heur a.m. While p. m. 19 | Not white facts | CE OF INJURY (Home, form, ory, street, office bldg., etc.) | 20f. (City or town) | (County) (State) |
| 21. I certify that I took charge of the reprince opinion death resulted from: Natural of ACTUAL SIGNATURE WHILE SIGNATURE SIGN | and a second | _ | Omicide [], Undetern | Inquiry , and in my mined monner BATE SIGNED Auf 31/59 |
| BURIAL 8/3/59 | WESTMINSTE | R CEM. | MESTMINS | STER, MD. |
| 23. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS | - / / . / . | BY REGISTRAN 246. REGISTI | RAR'S SIGNATURE |

DATE

SA TO DEPUTY A CAL EXAMINER execute the call the

EXAMINER: This certificate should be executed within 24 hours after death.

e, writing the word "pending" in pencil in Item, 18. Give Pages 1, 2, and ed to the Chief Medical Examiner's Office along with form PM3. Page 5 n



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| M | 1. PLACE OF DEATH a. COUNTY | Ca |

CERTIFICATE OF DEATH

| | | | | | | Kan. Dill. In | 0. |
|--|--|---|---|-----------------------------------|--------------------------------|----------------|---|
| 1. PLACE OF DEATH a. COUNTY | Carrell | MARYLAND | 2. USUAL RESIDENCE (W | | l. If institution b. COUNTY | Residence bel | |
| RURAL and give n | (If outside corporate limits, w legrest town) 1113ter | c. LENGTH OF STAY IN 16 | c. CITY OR TOWN (IF | outside corporale li Westminst | | RAL and give n | earest town) |
| d. NAME OF HOSPI OR INSTITUTION | TAL (If not in hospital, give s | | d. STREET ADDRESS | 101 E. | Main S | it. | e. IS RESIDENCE ON A FARM? YES NO A |
| 3. NAME OF DECEASED (Type or print) | Fint Thomas | Middle Christ | Amprazis | 4. DATE OF DEATH | July | 16 | Day Year 19 59 |
| 5. SEX | | MARRIED NEVER MARRIED DOWED DIVORCED DIVORCED | S. DATE OF BIRTH January 8, 1 | | | Months Doys | Hours Min. |
| 10a. USUAL OCCUPATI during most of wor Ret, Rest | | 106. KIND OF BUSINESS OR IND | - | e ar fareign country | | | OF WHAT COUNTRY |
| 13. FATHER'S NAME | Constant Aug | # | 14. MOTHER'S MAIDEN | - | | | |
| | Christ Amp | | | Zoe | | | |
| [Yes, 40, or unknown] | (If yes, give wor or dates of service) | 9) | informant frs. Popi S. A | Imprazis | Westmi | | Maryland |
| Conditions, if gave rise to coess (a), stating lying couse last. | the under: DUE TO | Hyperlus | in Cimbrely | Removed | 7-1 - | | 10 420 |
| ICATIC | 10% | ONS CONTRIBUTING TO DEATH BU DESCRIBE HOW INJURY OCCURR | | | | N IN PART I(a) | PERFORMED? YES NO |
| 20c. TIME OF INJU Hour o. m. p. m. | G □ CAUSE OF DEATH ' MEDICAL EXAMINER] RY Month, Day, Year 19 | 20d. INJURY OCCURRED 20e. P While Not while at work of work | PLACE OF INJURY (Home, far factory, street, office bldg., el | m. 20f. (City or to | wn) | (County | |
| olive on | Was Sennet | | M.D. 163 E | M, from the | couses or | on the deleter | saw the deceased of the stoted above pare signed with the signed with the stoted above. |
| 220. BURIAL, CREMATIC REMOVAL ISPACIFY BUTIEL | ON, 226. DATE THEREOF | 22c. NAME OF CEMETERY | | 22d. LOCATION | City, town, or | | (State) |
| 23. FUNERAL DIRECTOR | | ADDRESS | | D BY REGISTRAR | | RAR'S SIGNATI | |
| JOHN N. BY | ere Mesimi | REPORT A PROPERTY OF | DATEUL | 6 0 33 | COMM | "I de / WALL | _ |

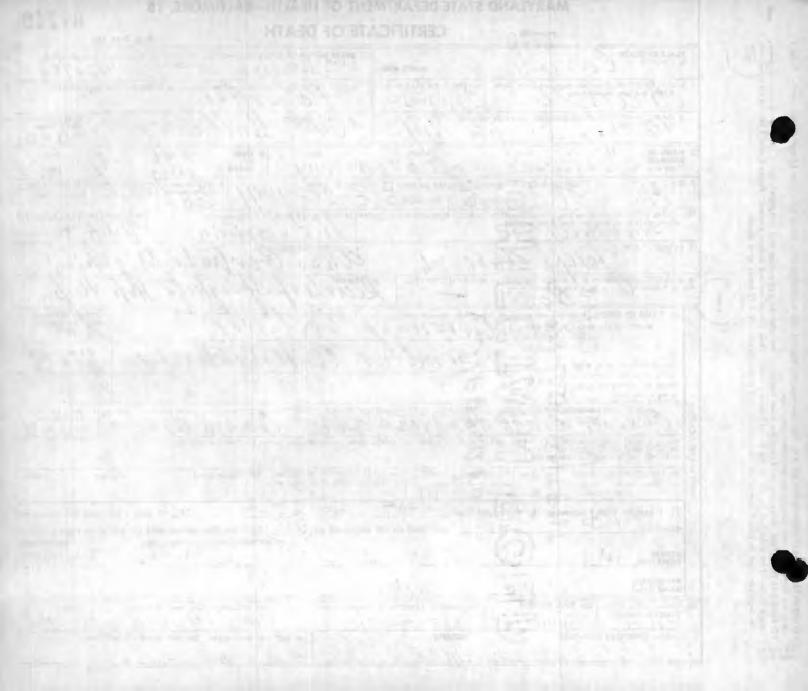
TO HOSPITAL INTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours. For death. Page 4 may be retained the hospital or attending physician.

TO FUNERAL DIRACOR: After this certificate has been signed by the attending physician and completely filled in by me funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, ar removal, and in any event within 72 hours, first death.

YS A15 (4) 15M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE. 18



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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TO HOSPITAL

VS A15 (4) 15M 9/5B

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7772 CERTIFICATE OF DEATH

07750

| | G ERTH 10. | | | Reg. Dist. No. |
|--|--|---|---|--|
| o. COUNTY Carroll | MARYLAND | | here deceased lived. If institution in the country b. COUNTY | Montgomery |
| PIPAL and give negrest town) | c. LENGTH OF STAY IN 16 2yrs. 8mos. 9da | | outside corporate limits, write R ma Park | URAL and give nearest town) |
| d. NAME OF HOSPITAL (If not in hospital, give street of OR INSTITUTION Springfield State Hospit | _ | d. STREET ADDRESS | Domer Ave. | e. IS RESIDENCE ON A FARM? YES NO |
| B. NAME OF First DECEASED (Type or print) Joseph | Perry Barker | Barber | 4. DATE Mon July | th 25, Year 19 59 |
| 5. SEX Male 6. COLOR OR RACE 7. MARRIE White Widowed | T, tared | January 17, | 9. AGE (In years lost birthday) 86 yrs. | Months Doys Hours Min. |
| Oa. USUAL OCCUPATION (Give kind of wark dane 10b. Kind uring mast of warking life, even if retired) Asst. Post Mast. G | | 1 | or foreign country) | U.S.A. |
| 3. FATHER'S NAME | | 14. MOTHER'S MAIDEN | NAME | |
| John Barber | | | Barker Barker | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes. no. or unknown) (If yes, give wor or dates of service) | | pringfield H | Add Ospital Records | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under-lying couse lost. | ateral bronch | - | | days |
| PAY II. OTHER SIGNIFICANT CONDITIONS CO. C.B.S. ASSOC. WITH CEPEDRAL 200. ACCIDENT WAS UNDERLYING TO OR CONTRIBUTING CAUSE OF DEATH URF EITHER, NOTIFY MEDICAL EXAMINER | AF VELLOSCIE! | OSIS WITH PS | yenotic reacti | PERFORMED? YES NO |
| | RIBE HOW INJURY OCCURRE | D. (Enter nature of injury in | Part I or Port II af item 16.) | |
| Hour a.m. While at wark | Not while fac | ACE OF INJURY (Home, farr ctory, street, affice bldg., etc | c.) | (Caunty) (State |
| 21. I certify that I attended the deceased alive on July 24, 1955 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Edmund Lusthaus | and that death | accurred at 3:15 | M, from the causes an ADDRESS (Street, city or town, gfield State He wille, Md. | d an the date stated above state) DATE SIGNET |
| 220. BURIAL, CREMATION, REMOVAL (Specify) | 22c. NAME OF CEMETERY O | R CREMATORY | 22d. LOCATION (City, town, | 1 |
| burial 7/27/59 B. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc. Raymond a. Girka | ADDRESS Silver Spr | | | STRAR'S SIGNATURE |

| | | | Service Service |
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| | nanivani | P + + . | Table 2 |

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7773 **CERTIFICATE OF DEATH** Rea, Dist. No. 1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY P. COUNTY MARYLAND b CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) d. NAME OF HOSPITAL (If not in hospital, give street address) e. IS RESIDENCE OR INSTITUTION ON A FARM? MALLWOOD YES NO 12 NAME OF DECEASED OF DEATH CLARENCE (Type or print) 19.5 6. COLOR OR RACE 7. MARRIED NEVER MARRIED IF UNDER 1 YEAR IF UNDER 24 HR AGE (In years lost birthday) Months WIDOWED [7] DIVORCED | papers. 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF 8USINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY during most of working life, even if retired) roq τŏ 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ELIZABETH BITTEL & ROOKS S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT -10-7900 MRS. MINNIE 1B. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c)] INTERVAL BETWEEN ONSET AND DEATH MYLOID LEUKEMIA PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (6) **DUE TO** Conditions, if ony, which gove rise to immediate **DUE TO** cotise (a), stoting the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFERNED? YES NO 🕮 20g ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month. Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f (City or town) (State) (County) Not while factory, street, office bldg., etc.) 0. m While of work of work p. m. S4, that I last saw the deceased 21. I certify that I attended the deceased fram and that death accurred at The M, fram the causes and another date stated above. COLMD. WESTHINSTER should I, WELL IVER NAME (Type) 22c. NAME OF CEMETERY OR CREMATORY 220 BURIAL CREMATION, 22b. DATE THEREOF 22d. LOCATION (City, town, or county) Trinity Luthern Cem. Smallwood, Maryland 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 24b. REGISTRAR'S SIGNATURE 24a, REC'D BY REGISTRAR John R. Byers Westminster. Md. DATE JUL 1 5 '59 VS A15 (4) arthur & Kraus

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07752 7774 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE Reg. Dist. No. HEALTH-DEPT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased I ved. If institution, Residence before admission) o. COUNTY **b** COUNTY MARYLAND b CITY OR TOWN I flow side corporate limits c. LENGTH OF STAY IN 1h TOWN (If puts'de corporate limits, write RURAL and give nearest lown) INSTITUTION (if not in hospital, give street address) d STREET ADDRESS IS RES DENIG ON A FARM? YES MO 3. NAME OF Lost Day Yeor DECEASED DEATH (Type or print) 19 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 1 8 DATE OF BIRTH 9. AGE Un years IF UNDER TYEAR Months Days Hours WIDOWED [7] DIVORCED T 100 USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY) 112 CITIZEN OF WHAT COUNTRY? during most of working life, even if entured) 4 13. FATHER'S NAME 14/MOTHER'S MAIDEN NAME pages ARMED FORCES 16 SOCIAL SECURITY NO Address war at dates at secure 18. CAUSE OF DEATH [Enter only one course per line for (o), (b), and (c)]/ INTERVAL BETWEEN PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 4001 DUE TO Conditions, if ony, which gave rise to immediate cause **DUE TO** (a), stoting the underlying couse last. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19, WAS AUTOPSY PERFORMED? 20g. EXTERNAL CAUSE WAS PRIMARY | 0 or CONTRIBUTING | CAUSE OF DEATH. 205 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 11 of item 18.) 20e PLACE OF INJURY (Home, form, 120f (City or town) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED (County) (State) factory, street, office bldg., etc.) While Not while of work of work p. m. 21. I certify that I took charge of the remains described above, held an Autopsy [7], Inspection X and in my opinion deoth resulted from: Notural causes X Accident . Suicide . Homicide . Undetermined manner orde CTO DIREC DATE SIGNED ACTUAL CHIEF MEDICAL EXAMINER SIGNATURE ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER TO NAME (Type) Shoul FUNE 22c. NAME OF CEMETERY OR CREMATORY 72d LOCATION (City, town, or county (State) 0 24b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR'S SIGNATURE 240, REC'D BY REGISTRAR Thouse A15ME 58A 2 57



3764 **CERTIFICATE OF DEATH** Rea. Dist. No M PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. COUNTY o. STATE **b.** COUNTY MARYLAND b. CITY OR TOWN (If outside corporale limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) d_NAME OF HOSPITAL (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? YES NO J. NAME OF 4. DATE OF DEATH First M'ddle Last Day Yeor DECEASED (Type or print) 19 7. MARRIED NEVER MARRIED 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 5. SEX 6. COLOR OR RACE B. DATE OF BIRTH lost birthdovi Days Months Hours DIVORCED [WIDOWED FT USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY 11 SIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if relired) 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT please 1B. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) **DUE TO** Conditions, if any, which gove rise to immediate **DUE TO** cotts (a), stating the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO 14 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Port I or Port II of item 18.] CERT OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month. 20e. PLACE OF INJURY (Home, form, Day, Year 20d. INJURY OCCURRED 20f. (City or town) (County) (Stote) factory, street, office bldg., etc.) Hour a. m. While Not while at work of work P. m. . 1959 that I last saw the deceased 21. I certify that I attended the deceased from. and that death accurred at 225 M, from the causes and an the date stated above. alive an ő ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE DIR P D PHYSICIAN'S NAME (Type) 220 BURIAL GREMATION, 22b. DATE THEREOF 22c NAME OF CEMETERY OF CREMATORY 22d. LOCATION (City, town, or county) (Stote) page Ē REMOVAL (Specify) 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRÉSS** 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE VS A15 (4) Cally & House 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



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| Page director | M | | 1. | PLACE OF DEATH COUNTY | oll | | MARYLAND | 2. USUAL RESIDE o. STATE MALT | | | b. COUNTY. | ris g | 2 6 |
| death. funeral | | / | L | RURAL and give ne Svkesvi | lle | . 28 v 11 | _ | c CITY OR TO | OWN (If outsi | | e limits, write R | Lllegany | nearest town) |
| by the | 1 |) | | d. NAME OF HOSPITA | At (If not in hospital, given State Hosp | ve street address) | | d. STREET AD | | | | | a. IS RESIDENCE ON A FARM? YES NO |
| within 24 haur stely filled in b Pages 1 and | 5 | 15 | | NAME OF DECEASED (Type or print) | First | | Middle Shall | lost Brode | 4. | DATE OF DEATH | Mon | | Day Year 11 1959 |
| d within sietely fa | n | | 5 | SEX M | 6. COLOR OR RACE | 7. MARRIED NEVER | MARRIED 3 | . DATE OF BIRTH | | 9. | AGE (In years lost birthday) 59 yrs. | *** | AR IF UNDER 24 HRS |
| execute nd camp | death. | | 100 | . USUAL OCCUPATIO during most of work minor | N (Give kind of work doing life, even if retired) | one 10b. KIND OF BUSH | VESS OR INDUST | | CE (State or f | foreign coul | itry) | 12 CITIZEN | OF WHAT COUNTRY |
| cate be sicion al | rs after | | | Ge orge | Broda. | | | 14 MOTHER'S N | MAIDEN NAM | | | | |
| h certifi ling phy se reman | אסי 72 ר | | 15. (Y= | no. or unknown) | If yes, give war or dates of ser | unkn | S | .S.Hospi | tal Re | cords | Add | ress | |
| that the death certificate by the attending physicia it. Then please remave co | ent within | | | PART I. DEAT | TH WAS CAUSED BY. IMMEDIATE CAUSE (6) | se per line for (a), (b), a Bilateral p | | g embolis | 3m | | | 11 | NTERVAL BETWEEN ONSET AND DEATH hours |
| res that red by the srmit. T | any ev | | | Conditions, if are gave rise to in | nmediate (| Thrombophle | bitis le | eft leg | | | | | days |
| w requi | , and ir | | Z. | cause (a), stating the lying cause lost. Part 11 OTH | (c) | infected alc | | | | L DISEASE (| OND TION GIV | /EN IN PART 1(o | weeks |
| The lang physical has be burial-to | гета | 2 | RTIFICATION | 20a. ACCIDENT WA | S UNDERLYING [] 2 | 10b DESCRIBE HOW IN. | JURY OCCURRED | (Enter noture of | INJURY IN PORT | 1 or Port II | of item 18) | | PERFORMED? |
| r attendi | tion, ar | | MEDICAL CER | (IF EITHER, NOTIFY | CAUSE OF DEATH MEDICAL EXAMINER) Month, Day, Year | | C-at- | CE OF INJURY (Ho | ome, form, | 20f. (City o | · lown) | (Coun | ly) (State |
| Spital a ter this | , cremo | | MEC | p. m. | at Lattended the | While Not while of work of work | | | | 11- | 1959. | that I last s | ow the deceased |
| ined by the ha DIRECTOR: Affilled be deteched | iar ta burial | , | | alive on ACTUAL SIGNATURE | 7-11- | 1459 ond | that death | accurred at | 1:30R _A | , fram th | e causes an et, city or town, | d an the do | pare stated above pare signer |
| | istrar pr | / | | PHYSICIAN'S NAME (Type) | dmund Lust | | | Sykesvi | | * | | | |
| O HOSPITAL may be reto O FUNERAL page 3 shou | the reg | | Bı | BURIAL, CREMAT OF REMOVAL (Specify) | 7-14-59 | F'bg. | Memor | ial Par | k | Fr | | g, Md. | |
| VS A15 (4) 15M 9/58 | 7 | 1 | 23. | J. R. I | | ADDRESS Ostburg, M | id. | 1 - | 24a. REC'D B DATE JÜL | | | STRAR'S SIGNA | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **CERTIFICATE OF DEATH**

Rea. Dist. No.

| 0775 |
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| | | PLACE OF DEATH S. COUNTY MARYLAND | 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission a STATE b COUNTY | n) | | | | | |
|---|---------------|--|---|-----------|--|--|--|--|--|
| | | b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b | c CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) | | | | | | |
| | 1 | Tural- dumber | Mural - Etamber | | | | | | |
| | ľ | OR INSTITUTION High material and the spirit, give street address. | d' STREET ADDRESS e IS RESIG ON A F YES | ARM? | | | | | |
| | | NAME OF PIRST Middle OECEASED (Type or print) Makerinet Clin | OF | 9.5 | | | | | |
| | 5 ! | WARRIED LI NEVER WARRIED | 8 DATE OF BIRTH 9 AGE (In year) IF UNDER 1 YEAR IF UNDER lost birthdown Manths Days Haurs | | | | | | |
| | 10a | USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDU | PUSTRY 11 BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT C | COLINITRY | | | | | |
| | | during most of working life, eyen if relired) Houselete | 772d. Zl. S. H | 2 | | | | | |
| | 13. | FATHER'S NAME BALLOR | 14 MOTHER'S MAIDEN NAME | | | | | | |
| | | | INFORMANT Address | | | | | | |
| | (¥e: | The or uninown) (If yes give wor or dotes of service) 11.71h - 11 | Mr Charles Brown - Westminster, The | ref. | | | | | |
| | | 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY | NIERVAL BET | | | | | | |
| | | IMMEDIATE CAUSE (e) | Carring Carried | ~_ | | | | | |
| | | Conditions, if any, which (b) Clarate (Conditions of the Conditions of the Condition | scular fleval alisans 16-13 | gra | | | | | |
| | | cause (a), storing the under- lying cause last (c) DUE TO Cyplitation (c) | ation Gillerin delerasor | | | | | | |
| 5 | CERTIFICATION | PANT II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT | UT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AT PERFORM YES 1 | MED? | | | | | |
| | ERTIFIC | 206 ACCIDENT WAS UNDERLYING 1 206 DESCRIBE HOW INJURY OCCURRED OR CONTRIBUTING 1 CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | RED (Enter noture at injury in Part I or Part II of stem 18.) | 110 | | | | | |
| | | | PLACE OF INJURY (Hame, farm, 120f (City or town) (Caunty) | (F1-1-1 | | | | | |
| | MEDICAL | | PLACE OF INJURY (Idame, form, ; 20) (City or town) (County) loctory, street, affice bldg , etc.) | (State) | | | | | |
| | | 21. I certify that I strended the deceased from | , 1959, to July 2, 1959, that I last saw the d | | | | | | |
| | | alive on 12 J gnd that death | th occurred at 1961 A.M. from the causes and on the date stated | l above | | | | | |
| | | ACTUAL WHEELEN FORETHE | as Westmunder and 1/2 | SIGNE | | | | | |
| | | PHYSICIAN'S NAME (TYPO) / W. GLENK SPE | ichER WestMinster, MD. | | | | | | |
| | 220 | BURIAL, CREMATION. 22b. DATE THEREOF 22c NAME OF CEMETERY C | 7/1/1/ | 1. | | | | | |
| | 23. | FUNERAL DIRECTOR'S SIGNATURE ADDRESS ' | 240 REC'D BY REGISTRAR 246 REGISTRAR'S SIGNATURE | P | | | | | |
| | 3 | telling theight Antroidle | JUL 7 59 Colling S. Frank | | | | | | |

may be retained he hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by The funeral director, page 3 should be detached far use as the burial-transit permit. Then please remove carban papers. Plages 1 and 2 should be filled with the registrar priar to burial, cremation, or remayal, and in any event within 72 haurs after death. TO HOSPITAL VS A15 (4) 15M 10/57

ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE Reg. Dist. No HEALTH DEPT 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) PLACE OF DEATH p. COUNTY ed!h. Balto. Chty MARYLAND Marvland Carroll b. CITY OR TOWN It outside corporate limits will BURAL c CITY OR TOWN (If autide corporate limits, write RURAL and give nearest town) c TENGTH OF STAY IN 16 Baltimore 19 13vrs_8mos_6days Sykesville d. NAME OF HOSPITAL OR INSTITUTION. (If not in hospital, give street address) d STREET ADDRESS S RECIDENCE ON & FARM 2911 Wells Ave. Springfield State Hospital YES NO 3. NAME OF Middle Month DECEASED July Brown Oscar Clifford (Type or print) DEATH 9 AGE (In years 6 COLOR OR RACE 7 MARRIED NEVER MARRIED B DATE OF BIRTH IF UNDER TYPAR IF UNDER 24 HRS lost birthday) Months Davi Hours February 10, 189 Male White WIDOWED DE DIVORCED [7] 100, USUAL OCCUPATION (Give king of work done 10b, KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if religed) Railroad & 0 (welder) North Carolina U.S.A. 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME - Whirchard Henry T. Brown 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO Springfield Hospital Records 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: hours Abdominal hemorrhage IMMEDIATE CAUSE (0) D 10.30 DUE TO (b) Thrombosis and rupture of mesenteric artery hours Conditions, if ony, which] gave rise to immediate cause (DUF TO (a), staling the underlying couse fost. PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY SCHIZOPHRENIC reaction, paranoid type. 20a, EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 11 of item (8) PRIMARY Tor CONTRIBUTING TO 20d INJURY OCCURRED | 20e PLACE OF INJURY (Home, form, | 20f. (City or fown) 20c. TIME OF INJURY Month, Doy, Year (County) (Stote) factory, street, office bldg., etc.) WED Not while of work of work 21. I certify that I took charge of the remains described blave, held an Autopsy 1, Inspection 1, Inquiry 19 apinion death resulted from: Natural causes ... Accident ... Suicide ... Hamicide ... Undetermined manner forward DIRECT DATE SIGNED CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER James T. Marsh. M.D. EXAMINER'S DEPUTY MEDICAL EXAMINER DO shrold FUNER NAME (Type) 220 BURIAL CREMATION 226 DATE THEREOF 22c NAME OF CEMETERY OR CREMATORY 27d LOCATION (City, town, or county) REMOVAL (Spec fy) BURIAL Moreland Park 0 Baltimore County

240 REC'D BY REGISTRAR 246, REGISTRAR 5 S GNATURE

DATE UL 1 6 '59

VII A15ME 5M 2/57 23. FUNERAL DIRECTOR S SIGNATURE

Wm. Cook. Inc., 1217 St. Paul Street



VS A15 (4) 15M 9/5B 43 W

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

ハウウドロ

| | | | | | | | Reg. Dist. I | Vo. 11 6 | 100 |
|--|---|-------------------------------|--------------------------------|---------------------|--------------------------------|------------------|---------------|----------------------|-------------------------------|
| o. COUNTY Carroll | | MARYLAND | 2. USUAL RESI | ryland | | If institut o | | efor e adm is | sion} |
| b CITY OR TOWN (f outside co | orporate limits, write | c LENGTH OF STAY IN TE | | TOWN (If outside | e corporate lin | sits, write R | JRAL and give | nearest low | n} |
| Sykesville | 3 | 4y 3m 10days | Balt | imore 5 | Md. | | | ii geti | |
| d NAME OF HOSPITAL (If not i | n hospitol, give street | address) | d STREET A | DDRESS | | | | | SIDENCE A FARM? |
| Springfield S | tate Hospi | tal | 2311 | E. Madi | son Ave | | | | NO |
| 3 NAME OF DECEASED (Type or print) | First William | Leo Middle | Calls | . 1 1 | DATE OF DEATH | Mon 7 | th | Day 4 | Year 19 59 |
| 5 SEX 6. COLO | R OR RACE 7. MARE | RIED NEVER MARRIED | B DATE OF BIRT | Н | P. AGI | E (In years | IF UNDER 1 YE | AR IF UND | ER 24 HRS |
| M W | WIDOW | | 5-24- | 84 | loss | birthdoy) yrs | Months Day | Hours | Min |
| 10a. USUAL OCCUPATION (Give k | ind of work done 10b. | KIND OF BUSINESS OR INC | DUSTRY 11. BIRTHPI | ACE (State or fo | reign country) | | 12. CITIZEN | OF WHAT | COUNTRY |
| during most of working life, ev | Am | p Holabird | Me | ryland | Balti | more | U.S | .A. | |
| 13. FATHER'S NAME | | | 14 MOTHER'S | MAIDEN NAME | | | | | |
| William Cal | lahan | | Mar | y Buch | heimer | | | | |
| 15. WAS DECEASED EVER IN U. S. (Yes, no, or unknown) (If yes, give w | ARMED FORCES? 16 or or date of service 2 | social security no. 3-14-5596 | S.S.Hos | pital R | ecords | Addr | ·@55 | | |
| 1B. CAUSE OF DEATH [Enter | only one couse per li | ne for (o), (b), and (c)] | | | | | | NTERVAL B | |
| PART I. DEATH WAS C | AUSED BY: | cute bronchop | neumonia | | | | | days | DEATH |
| 4411 | DUE TO | • | | | | | | | |
| Conditions, if ony, which | (b) | | | | | | | | |
| gove rise to immediate | DUE TO | | | | , | | | | |
| tying cause lost. | (c) | | | | | | | | |
| C.B.S. assoc. | with Circu | CONTRIBUTING TO DEATH B | IT NOT RELATED TO bance wit | h cereb | ral art | PO L'19 | CLeros | 19. WAS PERFO | AUTOPSY ORMED? |
| 200. ACCIDENT TO A CONTRIBUTING CAUSE (IF EITHER, NOTIFY MEDICAL I | OF DEATH EXAMINER | CRIBE HOW INJURY OCCUR | RED. (Enter noture o | of injury in Part I | or Port H of i | tem 18) | | | XE |
| | | NJURY OCCURRED 20e. | PLACE OF INJURY | Home, form, 20 | Of. (City or tow | /n) | (Cour | ity) | (Stote |
| 20c. TIME OF INJURY Month, | 19 While of wor | k ot while | foctory, street, offic | bldg., etc.} | | | | | |
| | | 0.0 | 24- 19 5 | · - | 7-4- | 10 50 | hat I last : | | |
| 21. I certify that I atte | ended the deceds 195 | | th accurred at | | | | | | |
| olive an 1-4- | , 122 | gand that dec | ith accurred at | | from the c RESS (Street, ci | | | | d abave T E SIGNE I |
| ACTUAL The | d J1 | , that | - Com | ingfield | | , | | | 7-4-5 |
| SIGNATURE | 000 | | _wp _ Spr. | ruRr terc | Draine | 1100 01 | , va.L | | |
| PHYSICIAN'S NAME (Type) Ed | mund Lugh | nus M.D. | Syk | esville, | Maryle | and, | | | |
| 220. BURIAL, CREMAT ON, 226. D | ATE THEREOF | 22c. NAME OF CEMETERY | | 22d. | LOCATION (| City, town, o | or county) | (Sto | ite) |
| Burlal 7/ | /8/59 | New Cathed | iral Cem | .] | Baltin | ore. | Md. | | |
| 23 FUNERAL DIRECTOR'S SIGNATE | | ADDRESS | | 24a REC'D BY | | | STRAR'S SIGNA | | |
| Schimunek Fur | leral Hom | e, Inc. | | DATE JUL | 7 '59 | C | when S. 9 | traves | |



VS A15 (4) 15M 9/58 H

| MARYLAND | STATE | DEPARTMENT | OF | HEALTH-BALTIMORE, | 18 |
|----------|-------|------------|----|-------------------|----|
| | | | _ | | |

7779 CERTIFICATE OF DEATH

Reg. Dist. No. 07759

|) 1 | a. COUNTY Carroll | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b COUNTYFrederick 121 | | | | | | |
|-------|---|---|---|--------------------------------------|---|--|--|--|
| | b CITY OR TOWN (If outside corporate limits, write RUPA, and give nearest lawn) Sykesville | utside corporale limits, write l | RURAL and give nearest lown) | | | | | |
| ٠ [| d. NAME OF HOSPITAL (If not in hospitol, give street or INSTITUT ON Springfield State Hospi | oddress) | d STREET ADDRESS 2.111 E.7th.St. o. IS RESIDENCE ON A FARM? YES NO. | | | | | |
| 3 | NAME OF DECEASED (Type or print) (Also Known A | s Lena Rottorf: Belle | Carter | 4. DATE Mg OF T DEATH | | | | |
| | Female 6. COLOR OR RACE 7. MARK | | 3-12-1 9 08 | 9, AGE (In yeors birthdoy) yrs | Manths Doys Hours Min. | | | |
| Ē | Ou USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Rectory worker** | KIND OF BUSINESS OR INDUST | Marylan | đ | 12. CITIZEN OF WHAT COUNTRY | | | |
| י | 3. FATHER'S NAME Ross Favorite | | 14. MOTHER'S MAIDEN N | Agnes Young | | | | |
| | 5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 (Yes, no. or unknown) (If yes, give wor or dates of service) | 7-10-0490 H | formant ospital reco | | dress | | | |
| | PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) D | | | NAL D.SEASE CONDITION GI | IVEN IN PART I(o) 19. WAS AUTOPS) PERFORMED? YES NO | | | |
| | OR CONTRIBUTING CAUSE OF DEATH | | CE OF INJURY (Home, form |), 20f. (City or tawn) | (Caunty) (State | | | |
| | 20c. TIME OF INJURY Month, Day. Year 20d II Haur a.m. 19 While p. m 19 of wor | IAOL MILIE | ary, street, affice bldg., etc | | | | | |
| , | 21. I certify that I attended the deceased fram 5-8- , 156 ta 7-19- , 159, that I last saw the decease alive on 7-19- , 1959 , and that death occurred at 10-10 M, fram the causes and an the date stated above ADDRESS (Street, city or town, state) ACTUAL | | | | | | | |
| 2 | 3. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Fre | ADDRESS ederick, Maryla | | | SISTRAR'S SIGNATURE | | | |



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 **CERTIFICATE OF DEATH** 7766Rea. Dist. No. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) p. COUNTY b. COUNTY MARYLAND b. CITY OR TOWN (If outside cosporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (IF outside corporole limits, write RURAL and give nearest fawn) RURAL and give nearest town) mmo d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO 3. NAMÉ OF 4. DATE Middle Month Day Year DECEASED DEATH (Type or print) 19 S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (in years IF UNDER I YEAR IF UNDER 24 HR last birthday) Months Days Hours WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR INDUSTRY IT BIRTHPLACE (State or foreign country)
during most of working life, eyen if refired) 12. CITIZEN OF WHAT COUNTRY? 13. FATHER'S-NAME 14. MOTHER'S MAIDEN NAME physicie IS. WAS DECEASED EVER IN U. S. ABMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (If yes, give war or dates of service) attending ecse 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c), INTERVAL BETWEEN ONSET AND DEATH ā PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE [6] 4 UNC **DUE TO** Conditions, if any, which gave rise to immediate **DUE TO** catse (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(g) 19 WAS AUTOPS PERFORMED? YES NO 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Manth, 20e. PLACE OF INJURY (Hame, form, 20f. (City or tawn) Day, Year 20d. INJURY OCCURRED (County) (State) factory, street, affice bldg., etc. Hour o.m. While Nat while at work at work 21. I certify that battended the deceased from 1401/ ., 1947, that I last saw the deceased z, and that death accurred at TOUTN, from the causes and an the date stated above. ADDRESS (Street, city or Jawn, state) SIGNATURE shauld PHYSICIAN'S NAME (Type) 22a. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d, LOCATION (Gity, town, or county) (State) REMOVAL (Specify) 23 FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 246 REGISTRAR'S SIGNATURE 240. REC'B BY REGISTRAR VS A1S (4) DATE AUG 3 Circling S. House '59 15M 9/S5



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VS A15 (4)

| | | I | | - d | 4 |
|---|---------------|--|---|---|---|
| The Idw requires that the deoin cermicole be executed within 24 hours | | s has been signed by the attending physician and completely filled in by the funeral director. | nurial-transit permit. Then please remave carbon papers. Pages 1 and 2 shauld be filed with | N | - |
| 4 HOULE | | ed in b | I and 2 shar | | |
| ured within 4 | | empletely fills | pers. Pages | ÷ | |
| COTE DE EXEC | | sician and co | ve carbon pa | ryditer deat | _ |
| geoin cermi | | ttending phy | pleose rema | within 72 hau | |
| res mor me | | ed by the a | ermit. Then | any event | |
| The law reduc | ig physician. | hos been sign | uriol-tronsit pe | emovol, and in any event within 72 haury after death. | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7767 **CERTIFICATE OF DEATH** Rea, Dist. No. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, (f institution: Residence before admission) Carroll Maryland **b.** COUNTY Carrall MARYLAND b CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) RURAL and give nearest town)
Westminster 35 years Westminster d. NAME OF HOSPITAL (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? 35 Hersh Avenue 35 Hersh Avenue YES NO P 4. DATE Middle Lost Year 195 DEATH 6. COLOR OR RACE 7. MARRIED A NEVER MARRIED 9. AGE (In years last purthday) IF UNDER I YEAR IF UNDER 24 HRS B. DATE OF BIRTH Months March 3, 1912 Days White WIDOWED [7] DIVORCED | 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (Slote or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Carroll County, Maryland USA Dry Cleaning 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME J. Grant Dell Ida Mae Allgire 16. SOCIAL SECURITY NO 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? Address 219-20-3813 Mrs. Anna M. Dell Westminster. Maryland INTERVAL BETWEEN ONSET AND DEATH ACCL USION **DUE TO** (b) DUE TO

no no 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 430.1 Conditions, if any, which gove rise to immediate corse (a), stating the underlying couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port II or Part II of item 18.)

(IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month. 20e. PLACE OF INJURY (Home, form, Day, Year 20d. INJURY OCCURRED

Hour a.m. While Not while at work of work p. m.

factory, street, affice bldg., etc.)

20f. (City or town)

(County) (Stote)

Unit 14 1959, that I last saw the deceased 21. I certify that I attended the deceased from and that death accurred at 33% M, from the causes and an the date stated above. ADDRESS (Street, city or town, state) **ACTUAL** 19 Ridge Road Westminster. Mi.

22c. NAME OF CEMETERY OR CREMATORY

Meadow Branch Cemetery

SIGNATURE PHYSICIAN'S NAME (Type)

a. COUNTY

3. NAME OF

5. SEX

CATION

CERTIFI

MEDICAL

DECEASED

(Type or print)

Male

William L. Stewart

7-17-59

19 Ridge Road Westminster. Maryland

REMOVAL (Specify) Burial 23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24g, REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

John R. Byers

220 BURIAL, CREMATION, 226, DATE THEREOF

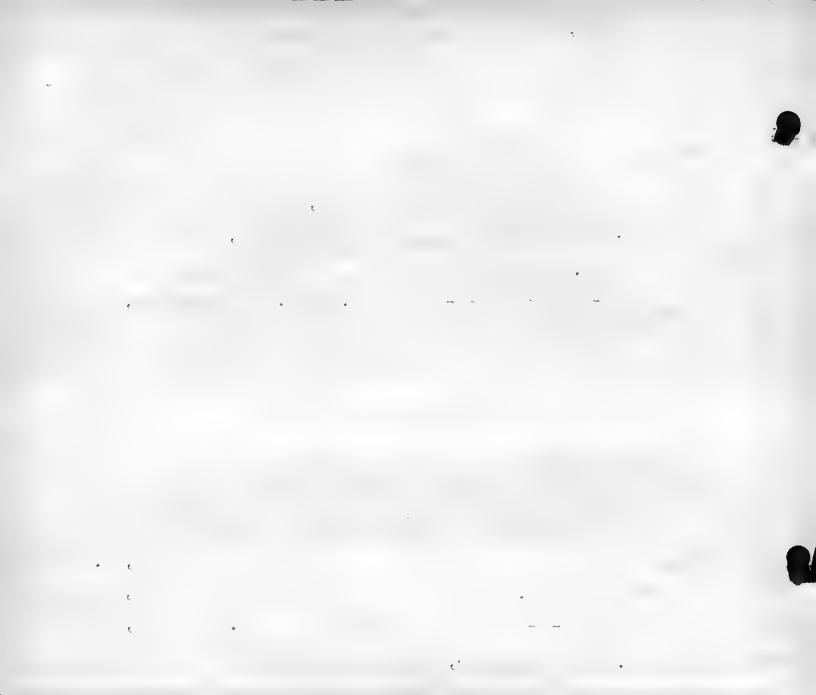
Westminster. Maryland

DATE JUL 1 6 '59

Thus & Krous

Nr. Westminster, Maryland

22d. LOCATION (City town, or county)



7780 **CERTIFICATE OF DEATH** Reg. Dist. No. 2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) 1. PLACE OF DEATH filed o. COUNTY **b.** COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write **ELENGTH OF STAY IN 16** c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest lown) d NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. 15 RESIDENCE ON A FARM? YES A-NO NAME OF First Middle Lost 4. DATE Month Year DECEASED OF DEATH (Type or print) 19 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED AT BEDATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. lost birthdoy) Months Doys Hours DIVORCED | WIDOWFD | 10a, USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) 16/116. 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME LON 16. SOCIAL SECURITY NO 17. INFORMANT Address 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BEJWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate DUE TO couse (o), stoting the underlying couse lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 166 19. WAS AUTOPSY PERFORMED? YES 🗍 NO-200. ACCIDENT WAS UNDERLYING TO OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I or Port II of item 18.) 20c, TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f (City or town) (County) (Stote) foctory, street, office bldg, etc.) Hour c. m. While Not while of work of work 21. I certify that I oftended the deceased from that I last saw the deceased alive on and that death occurred at PM, from the causes and on the date stated above. DATE/SIGNED ACTUAL PHÝSICIAN'S NAME (Type 220. BUR AL CREMATION. 22c. NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, town, or county) (Slote) REMOVAL (Specify) 9 23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 240. RECID BY REGISTRAR VS A15 (4) DATE 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE. 18



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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physician

attending

gned

DIRECTOR:

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15M 9/58



| | | CERTIFICATE OF DEATH Reg. Dis | | | | | | | | |
|--|--------------|---|---|---|--|--|--|--|--|--|
| M director | | PLACE OF DEATH C. COUNTY Carroll MARYLAND | 2 USUAL RESIDENCE (Where deceased lived If g. STATE Maryland b. C | ounty Baltimore | | | | | | |
| deoth. | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville 10mos.lidays | c CITY OR TOWN (If outside corporate limits, | | | | | | | |
| by the fun | * | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | d. STREET ADDRESS | e. IS RESIDENCE ON A FARM? YES NO | | | | | | |
| 124 haur illed in b ès 1 and | 3. | NAME OF First Middle DECEASED (Type or print) Levin Thomas | Dorsey January January | Manth Day Year | | | | | | |
| within within | 5. | 6. COLOR OR RACE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED | 8. DATE OF BIRTH 9. AGE (I | | | | | | | |
| d cam | | USUAL OCCUPATION (G.ve kind of work done 10b. KINB OF BUSINESS OR IND during mast of working life, even if retired) team engineer | LISTRY 11. BIRTHPLACE (State or fareign country) Maryland | 12. CITIZEN OF WHAT COUNTRY | | | | | | |
| المرات الم | | FATHER'S NAME Lenry Dorsey | 14. MOTHER'S MAIDEN NAME Anna Phelps | | | | | | | |
| death certificate ttending physicia please remave co within 72 haurs a | {Yı | WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. | Springfield Hospital | Address Records | | | | | | |
| the death | | 1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneus | nonia | INTERVAL BETWEEN ONSET AND DEATH Days | | | | | | |
| requires that ian. In signed by fl nsi permit. T | 1 | Conditions, if any, which gave rise to immediate cause (o), stoling the <u>under-lying cause lost.</u> DUE TO (b) DUE TO | | | | | | | | |
| The law rag physicic has been purial-trans emoval, or | FICAT ON | C.B. S. assoc. with circ dist., with cere psychotic reaction. 205. ACCIDENT WAS UNDERLYING IT 205. DESCRIBE HOW INJURY OCCUR. | THE RELATED THE FEW MAN DISEASE ON DETAILS. | CN GIVEN IN PART I(a) 19. WAS ALTOPSY PERFORMED? YES NO 2 | | | | | | |
| 4YSICIAN: or attendir s certificate ise as the b tation, or r | MEDICAL CERT | OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Day, Year Page 100. INJURY OCCURRED 100. While Not while 100. | PLACE OF INJURY (Home, form, 20f. (City or town) actory, street, office bldg , etc.) | (County) (State | | | | | | |
| TENDING PA the hospital ECTOR: After this e detoched far u r to burial, crem | I.W | 21. I certify that I attended the deceased from August 2 alive an July 5, 19/59, and that dea | 2, 1958, to July 6, th accurred at 8:30AM, from the country ADDRESS (Street, city of Springfield Hospit | or town, state) DATE SIGNE | | | | | | |
| be retail be retail III DiREC 3 shauld be egistrar prior | | PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. | Sykesville, Maryla | | | | | | | |
| O HOSPITAI may be reto m IUMIRAI poge 3 shar the registrar | | BURIAL CREMATION 226. DATE THEREOF 22c. NAME OF CEMETERY REMOVAL (Specify) 7-8-59 22c. NAME OF CEMETERY | very Saylow | wille Parcell will | | | | | | |
| VS A15 (4) 15M 9/5B | 23 | FUNERAL DIRECTOR'S SIGNATURE ADDRESS ADDRESS Winfield, The | 240. REC'D BY REGISTRAR 24 DATE 1 0 59 | Cillun S. Kraus | | | | | | |





VS A15 (4) 15M 9/58

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| Tohers. | Leath. | | |
| | offer dec | 1 | l |

7785 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist. No. 17767 **CERTIFICATE OF DEATH**

| | OF DEATH | | | | | 2. USUAL RESI | DENCE (W | here decease | d lived If instit | rutron. Res | idence be | fore admi | ssion) | |
|-------------|---|--|------------|----------------------------|---------|-----------------------|----------------------------|---------------|---------------------|-------------|---------------|------------|-------------------|--|
| a. COU | d. COUNTY Carroll MARYLAND | | | | | | II d. SIAIT an a b country | | | | | | | |
| | OR TOWN (IF L and give ne | outside corporate lin grest town) | uts, write | c LENGTH OF STAY | IN 1b | c. CITY OR 1 | OWN (IF | outside corpo | prote limits, write | RURAL | and give r | earest low | rn) | |
| | ykesví | | | | day | 8 | Cock | cevavi | lle | 031 | <u>K - 2.</u> | | | |
| OR II | NSTITUTION | AL (If not in hospital, | • | t oddress) | | d. STREET A | | | | | | ON | A FARM? | |
| Sp | ringfi | eld State | Hosp: | Ital | | J. | None | 9 | | | | 165 | NO P | |
| 3 NAME (| ED 03 | F | erst | Middle | | las | | 4. DATE OF | | Aonth | ı | Day | Year | |
| (Type or | print) | J | ohn | Raym | iond | Gard | ner | DEATH | J1 | uly | 2 | 2, | 19 59 | |
| 5. SEX | | | Z- MAR | RIED NEVER MARR | | | | | 9 AGE (In year | IF UN | | | DER 24 HRS | |
| Ma | le | White | WIDOW | VED DIVORCE | D FFP | • April | 2, 1 | 1892 | lost birthdoy | /rs Mont | ths Doys | Hours | Min | |
| 10a. USUA | LOCCUPATIO | N (Give kind of working life, even if retire | done 10b | . KIND OF BUSINESS O | OR INDU | STRY 11. BIRTHPL | ACE (Stote | or fareign c | country) | 12. | CITIZEN | DF WHAT | COUNTRY | |
| | borer | ng me, even ir reme | ٥) | _ | | Ma | rylar | nd | | | 17 | S.A. | | |
| 13 FATHER | | | | | | 14. MOTHER'S | | | | - | | | , | |
| Jo | hn Cha: | rles Gard | ner | | | | | a Herk | er | | | | | |
| 15. WAS D | ECEASED EVER | | | SOCIAL SECURITY NO |). I | NFORMANT | | | Á | ddress | | | | |
| Yes no or u | nknown] [I | I yes, give war or deles of | retaice) | 212-28-953 | 8 | Spr | ingf | ield H | ospital | Reco | ords | | | |
| 118 C | AUSE OF DEA | IH (Enter only one o | ouse per l | line for (o), (b), and (c) | 1 | | | | | | LIN | ITERVAL B | ETWEEN | |
| | | H WAS CAUSED BY | | | 4 | | | | | | 01 | NSET ANI | D DEATH | |
| 2 | 211 4 | IMMEDIATE CAUSE (| | Cerebral ar | teri | oscleros | 13 | - | | | | Year | 3 | |
|] 3. | 14-1 | DUE TO | | 7 | | | | | | | | 72 | | |
| | ditions, if an | , , | b) | Generalized | art | erioscie | rosia | 3 | | | | Year | 13 | |
| | rise to in (a), stating t | | 0 | | | | | | | | | | | |
| lying | couse last | | c) | | | | | | | | | | | |
| NO OF TO | PART IL OTH | ER SIGNIFICANT COI | ND TIONS | CONTRIBLTING TO DE | ATH BUT | NOT RELATED TO | THE TERM | AINAL DISEAS | E CONDITION | GIVEN IN | PART 1(o) | 19. WAS | ALTOPSY ORMED? | |
| S C B | 11d_d1 | abetes | - | sive disord | | | | | | | | | NO [| |
| C.E | CC DENT WAS INTRIBUTING HER, NOTIFY A | S UNDERLY NG CAUSE OF DEATH MEDICAL EXAMINER) | 20b. DE: | SCRIBE HOW INJURY C | OCCURRE | D. (Enter nature o | fin _t ury in | Port I or Pai | rt II of item 18.) | | | | | |
| | | Month, Day, Y | 204 | INJURY OCCURRED | 20a Pi | ACE OF INJURY (| Home for | 206 /5.6 | v as tavel | | 10 | | (Stote | |
| | lour a m. | 19 | While | B Not while | | ctory, street, office | | | y or rown; | | (Count | /1 | (2,016 | |
| 1 - | p. m. | | | ork at work | | 30 50 | Ψ. | 3 00 | | 70 | | | | |
| 21. 1 | | | e decea | sed fram. Sept | | | , ta_Ul | uly 22 | 19. | 2≯that | I last so | aw the | decease | |
| alive | on Ju | Ly 22, | , 19 | . <u>59</u> , and that | death | accurred at | 11: | 3MP from | the causes | and an | the da | te state | d abave | |
| | | | 0 | 10 | / | | | ADDRESS (S | Street, city or tov | vn, stole) | | DA | ATE SIGNE | |
| ACTUA | | Tushni | de | el Chru | 10. | M.D. Spr | ingf | ield S | tate Ho | spita | 1 | 7/ | /23/5 | |
| | ! // | 7 | | 1 | | | | - | | | | | | |
| | (Type)(/ | Agustin de | 1Cam | 00, M.D. | | Syk | esvi | lle, M | aryland | | | | | |
| 22a BUR-A | L, CREMATION | , 226 DATE THERE | OF | 22c. NAME OF CEM | ETERY O | R CREMATORY | | 22d. 10CA | TION (City, tow | n, or cour | nly) | (Sto | ote) | |
| REMO Bu | VAL (Specify) | 7/25/19 | 59 | Loudon | | | erv | | timore | | | vlan | _ | |
| | L PIRECTORS | SIGNATURE . | 100 | ADDRESS | | | 24a DEC | 'D RY PEGIS | TRAR 245 RE | GISTRAR': | | | | |
| 123 | me coline o | Ani. Com | 4600 | Liberty H | ghts | .Ave. | DATE J | UL 29 | 59 | Circhy | 1 8. 15 | aud | | |
| *** | 44 | ~ ~ ~ ~ ~ ~ | | | 0 | | 0.7710 | | | | | | | |



| 12/1 | | tem 20 Film 246 2741139 BEER DEPARTMENT OF HEALTH—BALTIMORE, 18 | |
|--|----------|--|-------------|
| FOR STATE | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | 18 |
| HEALTH DEP | L | Reg. Dist. No. 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission | |
| 28 E | × | o. COUNTY | 1 |
| Poge files. Health, |) h | b. CITY OR TOWN III cutside corporate limits, write RURAL C. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | * |
| Ser Ser | / | Sykesville Syrs.llmos.udays Baltimore | |
| i g | | d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e. S. RESID | IDMI |
| 8 9 | | Springfield State Hospital 509 1/1 Port St. | |
| fune fune State death | 1 | NAME OF DECEASED First Middle Lost 4 DATE Month Doy Year | |
| The shad | <u> </u> | (Type or print) Charles Fhillip Gross DEATH July 23, 195 | 59 |
| oy bear | | SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED 18 DATE OF BIRTH Male White WIDOWED DIVORCED June 26, 1890 9. AGE 10 years IF UNDER 19EAR IF UNDER 22. Months Days Hours Min | 4 HRS n |
| 5 m 5 m 5 m 5 m 5 m 5 m 5 m 5 m 5 m 5 m | | Male White WIDOWED DIVORCED June 26, 1890 69 yrs Month Days Noor Month Days No | INITE |
| ded ded and and | | during most of working life, even if refired) Laborer — Maryland U.S.A. | 13 41 114 1 |
| all the same of th | - | FATHER'S NAME 14. MOTHER'S MAIDEN NAME | |
| Page Page | | Charles Gross Johanna Pohlann | |
| orm or ite | | . WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOC AL SECURITY NO. 17. INFORMANT Address. | |
| Sign of the Control o | | No (If ye), give wor or dote; of service) 218-10-0933-A Springfield Hospital Records | |
| 1 8 1 8 1 9 1 9 1 9 1 9 1 9 1 9 1 9 1 9 | | 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c)] | |
| ored In a p | İ | PART I. DEATH WAS CAUSED BY. Asphyxia due to occlusion of larynx and Minutes | |
| Hin in Fice Proping | | 921.7 DUE TO pharynx with food | |
| Pend Pend Pend Pend Pend Pend Pend Pend | | Gonditions, if ony, which (b) gove rise to immediate couse | - |
| in in in it is to to | | (a), storing the underlying DUE TO | |
| ing ing as a strong as a stron | - 1 | PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19, WAS AUTO | DPSY |
| icoli of E of E | 7 | Schizophrenic reaction, chronic undifferentiated type. | |
| de de la companya de | | 20a. EXTERNAL CAUSE WAS PRIMARY OF OF ONTRIBUTING [2] 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I for item 18.) | |
| wor wor ould ourid | | Cause of Death. Aspirated food | |
| Chie T | 1 | While Not while O foctory, street, office bldg, etc.) | rate) |
| fing the the ige | 6 | | d |
| XAW X Ports | | 21. I certify that I took charge of the remains described above, held an Autopsy . Inspection . Inquiry . and in | ı my |
| Tope ager | | opinian death resulted fram: Natural causes . Accident . Suicide . Hamicide . Undetermined manner | |
| DIREC | | ACTUAL A MES DATE SIGN | ED |
| 9 9 3 5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 | | ASSISTANT MEDICAL EXAMINER [] | 150 |
| GE THE STATE OF STATE | | EXAMINER'S NAME (Type) James T. Marsh, M.D. DEPUTY MEDICAL EXAMINER (1) | צכ |
| Shauk shauk FUNEI | | BURIAL CREMATION 276 DATE THEREOF 22c NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) | |
| 2 4 2 5 | - | Durial 1-25-59 Holy Redeenser 14430 Below Rd. In | 10 |
| VS. A15ME | | FUNERAL DIRECTOR'S SIGNATURE SO TO SONARIES AT MONT CON AND 240. REC'D BY REGISTRAR'S SIGNATURE | |
| 5M 2/57 | Ŀ | Dartley Miller Juneral James DATE 159 Conting & Three | =- |



| 1 ~ | MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 |
|--|--|
| | 7787 CERTIFICATE OF DEATH Reg. Dist. No. |
| M vieto | 1 PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY C. KY. + |
| funeral | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest lown) And Color of Colo |
| D S Short | d. NAME OF HOSPITAL (If not in haspital, give street address or institution d. STREET ADDRESS d. STREET ADDRESS ON A FARM? YES NO |
| illed in es 1 on | 3. NAME OF DECEASED (Type or print) (Type or p |
| d within 2 Stetely fills | 5. SEX 6. COLOR DR RACE 7. MARRIED NEVER MARRIED 18. DATE OF BIRTH 9. AGE (In year) IF UNDER 1 YEAR IF UNDER 24 HRS. WIDOWED DIVORCED 7. Married North Days Hours Min. |
| execute nd comp n pape death. | 10a. OSUAL OCCUPATION (G ve kind of work done during roay of working life, even if retired) 12. CITIZEN OF WHAT COUNTRY? |
| icion or e carbo s after | 13 FATHER'S NAME IT A LY |
| ng phys e remov 72 hour | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 1st SOCIAL SECURITY NO. 12 INFORMANT (Yes, no. or unknown) (I yes, give wor or dates of service) Will Character to the contraction of the |
| the death the attendi Then pleas | 18 CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).] PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ONSET AND DEATH ONSET AND DEATH |
| equires that n. signed by i if permit. I | Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last, (c) |
| physicio os been ial-trans | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO 24 20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH OR CONTRIBUTING CAUSE OF DEATH OF CONTRIB |
| tending ficate has the burner of ar rem | |
| PHYSIC at ar at this cert r use as emotion | 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED Haur a. n. 19 While Not while at work at work at work 19 at work 19 Not while at work 19 Not work 19 Not work 19 Not while at work 19 Not |
| DING nospih After I ded for | 21. I certify that I attended the deceased from Nove 19.58, to July 25 1959 that I last saw the deceased |
| The HOR: Adetach | alive on |
| prior prior | SIGNATURE 1/1 (1 / Mur full m.o. Hampstead, Md 7/27/59 |
| OSPITAL N be reloin NERAL D Se 3 should registrar pr | PHYSICIAN'S NAME (Type) M. C. Porterfield, M. D. Harbstead, Md |
| MOY B MOY B Poge (| 220 BURIAL CREMATION, 22b. DATE THEREOF 224 NAME OF CEMETERY OF CREMATORY 72d. LOCATION (City town, or country) (Slater) |
| VS A15 (4) 15M 9/55 | 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE JUL 2 8 159 Conclus 8. Known |



law requires that the death certificate be executed within 24



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Rea. Dist. No. HEALTH DEPT. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived If institut an Residence before admission) a. COUNTY MARYLAND Heal c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lawn) NSTITUTION (final inhaspital, give street address) ON A FAR AS YES PI NO 3. NAME OF Year DECEASED (Type or print) DEATH 6 COLOR OR RACE 7. MARRIED FT NEVER MARRIED TIB DATE OF BIRTH 9 AGE (In years IFUNDER TYPAR Months Hours WIDOWED 100 USUAL OCCUPATION (Give kind of work done) 106 KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? ARMED FORCES? 17 INFORMANT 18. CAUSE OF DEATH | Enter only one couse per line for (o), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if ony, which gave rise to immediate cause **DUE TO** (a), stoting the underlying cause fast. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBLTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? 20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Fort II of Item 18) CAUSE OF DEATH. 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f (City or fown) 20c. TIME OF INJURY Month, Day, Year (County) (Stote) factory, street, affice bidg., etc.) Not while, While of work of work p. m 21. I certify that I took charge of the remains described obove, held an Autopsy []. Inspection [M], Inquiry [opin on death resulted from Notural causes 📈 Accident 🗍 Suicide 🗍 Hamicide 📗 Undetermined manner DATE SIGNED CHIEF MEDICAL EXAMINER SIGNATURE ASSISTANT MEDICAL EXAMINER EXAMINER'S DEPUTY MEDICAL EXAMINER D NAME (Type) 220 BURIAL CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OR PREMATORY 22d LOCATION (City, fown, or county) REMOVAL (Spe Ty) 23. EUNERAL DIRECTOR'S SIGNATUR 240 FEC'D BY REGISTRAR 246 REGISTRAT'S SIGNATURE VS. A15ME 5M 2.57



| MARYLAND | STATE DEPART | MENT OF H | EALTH— | BALTIM | ORE, 1 | 8 | - (| 177 | 79 |
|-----------------------------|------------------------------|-------------------------|------------------|-----------------|--------------------------|-----------|-----------|-----------|----------------|
| 7789 | CERTIFIC | CATE OF D | PEATH | | | Reg. Di | | | • / |
| | MARYLAN | g. STATE | DENCE (Where of | | If institution b. COUNTY | | to Ci | | on) |
| corporate limits, write | c LENGTH OF STAY IN 1 | lb c. CITY OR 1 | OWN (If autsid | - | mits, write RC | | | | } |
| n) | 6yrs.8mos.26 | days | Baltimo | re 2 | | | | 7 | |
| in haspital, give stree | t address) | d. STREET A | DDRESS | | | | | . IS RESI | DENCE FARM? |
| tate Hospi | tal | | 410 E. | Oliver | Stree | t | | | NO 🔀 |
| First | Middle | Las | 4. | DATE | Mant | h | Day | γ | fear |
| George | Harris | Jefi | ers | DEATH | Jul | y | 4, | 1 | 959 |
| OR OR RACE 7 MAI | RRIED A NEVER MARRIED | 8. DATE OF BIRTI | Н | 9 AC | E (In years | | 1 YEAR | | |
| ite widov | VED DIVORCED | July 17 | , 1880 | 7 | birthdoy) | Manths | Days | Haurs | Min. |
| kind of work dane 10b | KIND OF BUSINESS OR IN | NDUSTRY 11, BIRTHPL | ACE (State or fo | | | 12.CIT | IZEN OF | WHATC | OUNTRY |
| orator | - | Ma | ryland | | | | U. | S.A | |
| | | 14. MOTHER'S | MAIDEN NAME | | | | | | |
| es H. Jef | fers | 10 | **** | Chri | stina | Weid | lner | | |
| ARMED FORCES? 16 | , SOCIAL SECURITY NO. | INFORMANT | | | Addre | 933 | | | |
| 2 | 13-14-2070 | Springfi | leld Hos | pital | Record | 3 | | | |
| er anly ane cause per | line far (a), (b), and (c)-) | | | | | | INTER | RVAL 8E1 | TWEEN. |
| CAUSED 8Y: ATE CAUSE (o) | Bronchop | neumonia | | | | | | AND | DEATH |
| DUE TO | 22 041041014 | | | | | | | | |
| h) as | | | | | | | | | |
| (b) | | | | | | | | | |
| (c) | | | | | | | | | |
| FICANT COND TIONS | CONTRIBUTING TO DEATH | BUT NOT RELATED TO | THETERMINAL | D SEASE CON | IDITION GIVI | EN IN PAR | T 1(o) 19 | . WAS A | UTOPSY |
| rebral art | erios cleros is | • | | | | | 1 | PERFO! | RMED? |
| LYING 🗆 206. DE | SCRIBE HOW INJURY OCCU | IRRED (Enter noture o | Finjury in Port | or Port I. of | item 18) | | | | |
| E OF DEATH EXAMINER) | | | | | | | | | |
| Doy, Year 20d. | INJURY OCCURRED 20e | PLACE OF INJURY | Home, form, 2 | Of (City or to | wn) | (| Caunty) | | (State |
| 19 While | e Nat while | foctory, street, office | blog , etc.) | | | | | | |
| anded the decor | sed from October | 20. 10 51 | July | · La | , 1959, | that I la | | الد ما | |
| . 19 | FA | ath occurred at | | | | | | | |
| // | / | | | RESS (Street, d | | | e dare | | E SIGNE |
| - J I | wollease | Spri | ngfield | | | , | | 7/5/ | co. |
| | | M.D | ii.Pr roxia | 11000 | 901 at. | | J | 1_21_0 | 11 |
| und Lustha | us. M.D. | Sylve | sville, | Marwl | กาส | | | | |
| DATE THEREOF | 22c. NAME OF CEMETER | | | LOCATION (| | r caunivi | | (State | |
| 7-8-59 | | ark Cemete | 1 | **** | timor | | | (Januar) | ri . |
| TURE | ADDRESS | -all Come ve | 24a. REC'D 8Y | | , | | GNATURI | Ě | |
| | | | Bann C | A DO | | | | | |



VS A15 (4) 15M 9/5B

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7790 CERTIFICATE OF DEATH Reg. Dist. No.

| 1. PLACE OF a. COUNT | Carroll | | MARYLAND | 2. USUAL RESIDEN | _ | | lived. If instituti b. COUNTY | on: Resider | nce befor | re admissi | ion) |
|---|--|----------------|--------------------------|--------------------------|----------------|-------------|------------------------------------|-------------|-----------|------------|-----------------------------|
| | R TOWN (If outside corporate limi | its, write | c. LENGTH OF STAY IN 1b | 1 | rylan | | ote fimils, write R | U.L.U | June Dec | tout tour | 1 |
| RURAL | and give nearest town) | 110, 11110 | | | | | | CKAL OILG | give nec | # | , |
| | Kesville OF HOSPITAL (If not in hospital, c | | 9 m 8 d | | more | I'IC | ž o | | , | ¥ | LD 52 155 |
| OR INS | STITUTION | | | d. STREET ADD | | | | | 1 | | FARM? |
| Sp | ringfield State | Hosp | ital | 3228 0 | littm | ont A | 746 | | | YES [| NOTE |
| 3. NAME OF DECEASES | Fir | 'st | Middle | Last | 4. | DATE | Mor | | Do | | Year |
| (Type or p | orint) Jan | 105 | Si | Jensen | | DEATH | 7- | | 3 | 1 | 19 59 |
| 5. SEX | 6. COLOR OR RACE | 7. MARI | RIED NEVER MARRIED | B. DATE OF BIRTH | | 9 | , AGF (In years last birthday) | | | | ER 24 HRS. |
| M | W | WIDOW | ED DIVORCED | 5-22-85 | 5 | | 7/ yrs | Months | Days | Hours | Min. |
| 10a USJAL | OCCUPATION (Give kind of work | done 10b. | KIND OF BUSINESS OR INDU | STRY 11. BIRTHPLAC | E (State or fi | oreign cou | intry) | 12 CIT | IZEN OF | WHATC | OUNTRY? |
| - | nast of warking life, even if retired | | etired 3 vr | Denne | ande. | | | 20 | nsicac | TIS | SA |
| 13. FATHER'S | ol & dan maker | | etired 3 yr | 14. MOTHER'S MA | | E | | | | 0 1 | ~ |
| S | aliach Jensen | | | Chri | stine | | ? | | | | |
| | EASED EVER IN U.S. ARMED FOR | CES? [16. | SOCIAL SECURITY NO. | INFORMANT | | | Add | ress | | | |
| (Yes, no, or unk | | 2 | 13-034-327 | S.S. Hosp | oital | Reco | rds | | | | |
| no | Mar de annual for | | | | | | | | Louis | | |
| | JSE OF DEATH {Enter only one co PART I. DEATH WAS CAUSED BY: | | - | | | | | | ONS | ERVAL BE | DEATH |
| | IMMEDIATE CAUSE (o) Septimenta weeks | | | | | | | | | | |
| 1 77 | 7/4 DUE TO | | | | | | | | | | |
| Conditions, if ony, which Multiple decubitus ulcers | | | | | | | | | weeks | | |
| | gove rise to immediate Couse (a), stating the under- | | | | | | | | | | |
| | lying couse lost. (c) | | | | | | | | | | |
| C.B 20a ACC OR CON (IF EITHE | S. assoc WILL | reter | SALLANG OUT OF SALES | 893915° W1 | the pay | PARASE | each don | 'EN IN PAI | T 1(o) 1 | | AJTOPSY RMED? |
| € 200 AC | CIDENT WAS INDEDIVING TO | onl nec | CRIBE HOW INJURY OCCURRI | D (Enter on tree of in | iner a Best | Los Park | II of item 18 1 | | | 1E2 | NO LX |
| | CIDENT WAS UNDERLYING THE INTERPRETATION OF DEATH (C. NOTIFY MEDICAL EXAMINER) | 20b. DE3 | CRIBE HOW INJURY OCCURR | D. (Enter notore of in | iloth in Lott | 1011011 | n or nem re-) | | | | |
| | E OF INJURY Month, Day, Ye | | L L | ACE OF INJURY (Hor | | 20f (City o | or town) | (| County) | | (State) |
| A Ho | p. m. 19 | While of wor | | ctory, street, office bl | og., erc.) | | | | | | |
| | | | 70.2 | 19 58 | ·- '7 | 73 | , 19.55 | AL | | .1 1 | |
| | ertify that I attended the | | ca nom | occurred at 7 5 | | | | | | | |
| olive | on | , 19_# | 22_/_/, and that death | occurred atte | | | he causes an eet, city or town, | | e date | | i obove. E signed |
| ACTUAL | 9 12 | 1 | 1. 11. | | | | | | | | L=59 |
| SIGNATI | URE CAL PLACE | 7 0 | 2000 Car | mo Spri | ngfiel | ld St | ate Hosp | Jrar | | | 4-27 |
| PHYSICI, NAME (1 | AN'S Edmund La | sthai | as M.D. | Syke | sville | e, Ma | ryland. | | | | |
| | CREMATION, 22b. DATE THEREC |)F | 22c. NAME OF CEMETERY C | OR CREMATORY | 220 | I. LOCATI | ON (City, town, | or county) | | (Stot | e) |
| Buria | AL (Specify) | ~0 | Lorraine Pa | | D | 07+4 | more M | a | | | |
| | DIRECTOR'S SIGNATURE |) y | ADDRESS | 24 | la. REC'D BY | | | | GNATU | RE | |
| HENRY | | S.IN | C. Baltimore | Md. | AUL 7 | '59 | | my & 1 | | | |



requires that the death certificate be executed within



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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May be retained by Control of EUNERAL DIRECTOR: A Doge 3 should be detaching to buri

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law requires that the death certificate be executed within 24



| 1 | | MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | es file sa file co. |
|---|---------------|--|---|
| | | 7794 CERTIFICATE OF DEATH | st. No. |
| a M | t. | PLACE OF DEATH COUNTY ARROLL MARYLAND 2 USUAL RESIDENCE (Where deceased lived If institution Resident COUNTY ARROLL MARYLAND 2 USUAL RESIDENCE (Where deceased lived If institution Resident COUNTY ARROLL) | ice before admission) |
| ad pa | | C. CITY OR TOWN (If outside corporate limits, write RURAL and RURAL and give nearest town). | |
| 7 2 sho | | d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | o, is residence ON A FARM? YES NO |
| 5 2 3 | | NAME OF DECEASED (Type or print) ELIZABETH HELENE KLAATSCH DEATH July | 28 1959 |
| | 5 : | MIDOWED BY DIVORCED 1 Jan 8, 1846 63 yrs Manths | |
| death | | USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11 BIRTHP(ACE (State or foreign country) during most of working life, even if retired) A V T T V G ERHANY FATHER'S NAME | FRITH NY |
| | | HERMANN KLAATSCH HELENE SPANGE! | VBERG |
| n 72 ho | (Ya | 100 or unknown) (18 yes, give war or doles of service) Thorse. Heinz & Klastily M.D. Fel. | |
| nt within | | 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY Myocardial Insufficiency IMMEDIATE CAUSE (o) Myocardial Insufficiency | INTERVAL BETWEEN |
| ony eve | | Conditions, if ony, which gove rise to immediate (b) Metastatic Carcinomatosis | months |
| and in | z | lying couse lost. DUE TO (c) Ca of Uterus | 2 years |
| emavol, | CERTIFICATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PAR 200 ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of Item 18.) | PERFORMED? |
| 2 | ICAL CERT | OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| тетойо | MEDIC | Hour o. m. While Not while foctory, street, office bldg., etc.) p. m. 19 of work of work | County) (State) |
| buriol, c | | olive onUULY 20, 19_22_, and that death accurred at 0M, from the causes and on t | |
| rior to | | ACTUAL SIGNATURE Riles S. S. H. S. J. Leve I Me. | Mal 7-29 |
| gistror p | - | PHYSICIAN'S NAME (Type) Dr. Rita S. Glahn Sringf. State Hosp. Sykesville, Md. | |
| | 1. | BURIAL CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) REMOVAL Specialty AUG 6 /139 Office ADDRESS ADDRESS 24m. RECID BY DECISTRAP 24h. REGISTRAPS SIGNATURE | (Stole) |
| 4) 57 | 13 | FUNERAL DIRECTOR'S SIGNATURE ADDRESS SNATURE / |



Page 4 may be retain the hospital are taking physician. TO FUNERAL DIFFICURE After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shauld be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. death ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs

TO HOSPITAL

VS A15 (4) 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 7795

CERTIFICATE OF DEATH

Reg. Dist. No.

| 1 | | | | | | | | |
|---|---------------|--|---------------------------|-----------------------------------|------------------------|------------------------------------|-------------------------------|--------|
|) | | LACE OF DEATH COUNTY A PRO // | MARYLAND | 2 USUAL RESIDENCE (WI 0. STATE | | If institution Residence COUNTY | re before admission) | |
| | t | CITY OR TOWN (If autistic corporate limits, write RUBAL and give rearest town) | c. LENGTH OF STAY IN 16 | c. CITY OR TOWN (IF 5 | | nils, write RURAL and g | ive nearest town) | |
| | | WIHA Chester | 2/ nanelles | Harro | -rev | | | |
| } | 7 | OR MISTITUTION | oddress) | d. STREET ADDRESS | 7. 7 | 101 | e. IS RESIDENCE ON A FARM? | , |
| | | Jing alw Musery | John | 1270 | I nia | Up or | YES NO | > |
| | | VAME OF First / First / Type of print) | Trillian. | Merry | 4. DATE OF DEATH | Manth | Day Year | 7 |
| • | 5. 5 | male white widows | | B. DATE OF BIRTH | 186 79. KG | 1.1.1.1.1 | Doys Hours Min | |
| 1 | 1000 | USUAL OCCUPATION (Give kind of work done 10b. | KIND OF BUSINESS OR INDU | STRY 11 BIRTH LACE (Stote | or foreign country) | 12 CIT | ZEN OF WHAT COUNTR | Y? |
| | 1. | during most of working life, even if retired) | | Briney | token | دن ۱ | 215A | |
| | 13 | FATHER'S NAME | | HA MOTHER'S MAIDEN | NAME () | . /' | , | |
| | | tacoh Allrio | | Maria | X-E | 7 | | |
| | 15 | WAS DECEASED EVER IN U. S ARMED FORCES 16. | SOCIAL SECURITY NO. 17 | NEGRMANT | 00/3 | Address | 1 | |
| | | (no for unknowed) (14 yes, give war of dates of service) | 99-07/7989 | X140 h Xain | I Then | 7 dan | mer 19 | |
| | | 18. CAUSE OF DEATH [Enter only one cause per lin | ne for (0), (b), and (c) | () | 2 1 1 | 7 | INTERVAL BETWEEN | _ |
| | | PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) | (three. | Myreur | deline | * | ONSET AND DEATH | |
| | | 422.1 DUE TO | | 61 | | 4 | | |
| | | Canditions, if ony, which) butte | au- schurte | i Carker (| Poscelas | Suscerie | ٠ | |
| | | gave rise to immediate DUE TO | | | | | | |
| | | lying cause lost. (c) | | | | | | |
| | Ö | PART II OTHER SIGNIFICANT CONDITIONS | CONTRIBUTING TO DEATH BUT | NOT RELATED TO THE TERM | INAL DISEASE CON | DITION GIVEN IN PART | 1(a) 19 WAS AUTOFSY | |
| 3 | 7 | | | | | | PERFORMED? | - |
| | CERTIFICATION | 20g. ACCIDENT WAS UNDERLYING 1 20b. DESC OR CONTRIBUTING 1 CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | CRIBE HOW INJURY OCCURRE | D (Enter nature of injury in | Part I or Part II of i | tem 18) | | |
| | | | JURY OCCURRED 20e. PL | ACE OF INJURY (Home, form | I not seen a see | | | |
| | MEDICAL | Hour o.m. While | Not while for | clory, street, office bldg., etc | - City of tow | m) (C | ounly) (State) | J |
| | | 21. I cortify that I attended the decease | ed from /i | 19-12, to | 11/3 | 19/79 that L.I | ast saw the decease | ad |
| | | alive an Liky 13 19V | 9 and that death | Car E | N. from the | | e date stated above | |
| | | | 1/2 1/ | 28/ | ADDRESS (Street, ci | | DATE SIGN | |
| | | ACTUAL SIGNATURE | Justa | M.D Hours | sligh | May Ca | nd 7/13/ | 13 |
| 1 | | PHYSICIAN'S 168077 6 | Bush M | O HAMAD | SFEAT | (Jany) | and | |
| | 220 | BURIAL CREMATION, 225/DATE THEREOF | 200 NAME OF CEMETERY O | R CREMATORY | 22d/10CATION (0 | City fown, of cooply) | (5)01(1) | |
| | 1 | Jean 1/6/17 | 198 Will | 18th | 7 fluen | Us Jar | Joks W | |
| , | 23 | FUNERAL DIRECTOR'S SIGNATURE | ADDRESS A | | D BY REGISTRAR | 246 REGISTRAR S SIG | / - | |
| | | Mricaries 124ch | is Human | 17 JATE III | 1 6 '5.9 | Culling d. 1 | tracel | |

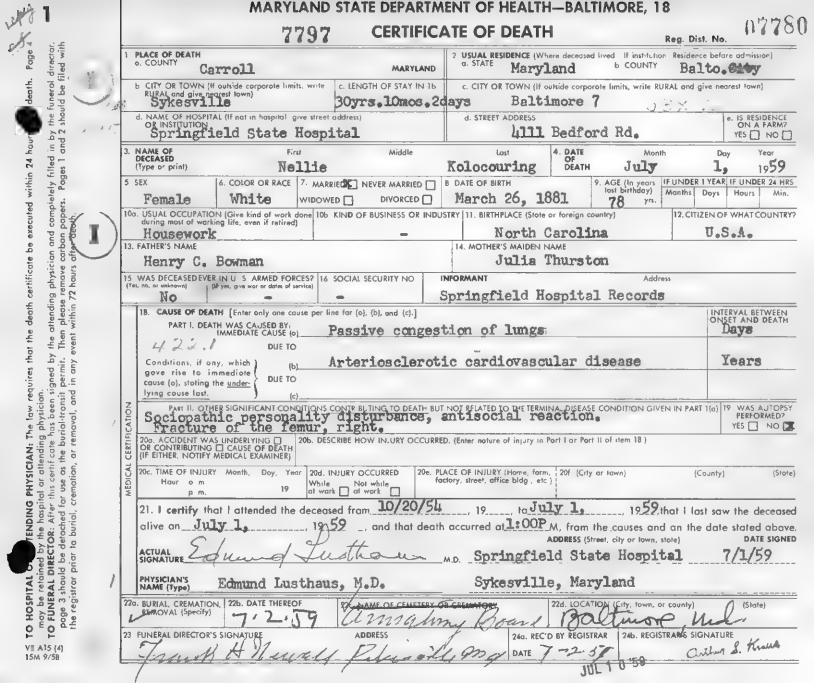


death, Page

The law requires that the death certificate be executed within 24

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18







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V5 A1S (4) 1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 98 CERTIFICATE OF 07781 CERTIFICATE OF DEATH Reg. Dist. No. b COUNTY Howard Maryland MARYLAND E LENGTH OF STAY IN 16 Ellicot City 32Y11M20D d. STREET ADDRESS

2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown) Sykesville d. NAME OF HOSPITAL (If not in haspital, give street oddress) e. IS RESIDENCE ON A FARM? Unimown Springfield State Hospital. YES NO First Middle 4. DATE Last Month Elizabeth 7⇔ Anna Korper DEATH 6. COLOR OR RACE 7. MARRIED IN NEVER MARRIED 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 15 yrs. 2- 7 -1884 Months Days Haurs White DIVORCED [WIDOWED [10a USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or fareign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) U.S.A. Maryland 14. MOTHER'S MAIDEN NAME Frederick Bauer Annie E. Kamm 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT Address Sykesville, Maryland, Hospital records 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN Acute peritonitis PART I. DEATH WAS CAUSED BYIMMEDIATE CAUSE (a) days DUE TO Perforated ulcerated Sigmoid diverticulum days Conditions, if ony, which gove rise to immediate **DUE TO** cause (o), stating the under-PART IF, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? YES NO 20g ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item 18.) 20c. TIME OF INJURY Month, Doy, Year 20e. PLACE OF INJURY (Hame, farm, 120f. (City or town) 20d. INJURY OCCURRED (County) (Stote) factory, street, office bldg., etc.) While Not while at work ot wark 21. I certify that I attended the deceased from ,that I last saw the deceased and that death occurred a 10.50P A, from the causes and an the date stated above ADDRESS (Street, city or lawn, state) DATE SIGNED Springfield State Hospital Sykesville, Maryland, Agustin del Campo. M. D. 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d LOCATION (City town, or county) (Stote) EMOVAL (Specify) 23 FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 24g. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

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| MARYLAND | STATE DEPARTMENT | OF | HEALTH-BALTIMORE, | 18 |
|----------|------------------|----|-------------------|----|
| 7799 | CERTIFICATE | OF | DEATH | |

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Circhar & House

Rea. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased fixed. If institution; Residence before admission) a. COUNTY g. STATE b. COUNTY MARYLAND Montgomery Carroll Mary Land b. CITY OR TOWN (If autside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) RURAL and give nearest tawn) Svkesville days Silver Spring d NAME OF HOSPITAL (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital 2101 Hildarose Drive YES TO NO I'M NAME OF Middle Lost DATE Month DECEASED Charles Edward DEATH July 1959 (Type or print) Love 20. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 9 AGE (In years 5. SEX 8. DATE OF BIRTH IF UNDER I YEAR IF UNDER 24 HRS last bigthday) Months Days July 30, 1885 Male White WIDOWED I DIVORCED | 73 yrs. 10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY during most of working life, even if retired) Potomac Power Co. Virginia U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME -Unknown -Unichown IS, WAS DECEASED EVER IN U. S. ARMED FORCES? INFORMANT Springfield Hospital Records No 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN CONSET AND DEATH PART I, DEATH WAS CAUSED BY Rheumatic valvulitis, inactive, with deformity IMMEDIATE CAUSE (a 410 X of valve (mitral) DUE TO Canditians, if any, which gave rise to immediate DUE TO cause (a), stating the underlying cause last. PART 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY CHRONIC brain syndrome associated with arteriosclerosis. YES NO CERTIF 200. ACCIDENT WAS UNDERLYING TO OR CONTRIBUTING TO CAUSE OF DEATH 206. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part or Part II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Year Day, 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f (City or town) (County) (State) factory, street, affice bldg., etc.) a. m. While Not while at wark at work to July 21 I certify that I attended the deceased from July that I last saw the deceased , and that death occurred at 6:20PM, from the causes and an the date stated above. alive an July ADDRESS (Street, city or town, state) DATE SIGNED **ACTUAL** Springfield State Hospital SIGNATUR PHYSICIAN'S Agustin delCampo. M.D. Sykesville, Maryland NAME (Type) DATE THEREOF 22a. BURIAL, CREMAT ON. 224 NAME OF COMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24b. REGISTRAR'S SIGNATURE 24a, REC'D BY REGISTRAR



07783

| Sykesville 6 days Baltimore 6 | | | | | | | | | 3 .70 | | , | | |
|-------------------------------|---|--|--------------|--------------------------|-----------------------------------|----------------------|---------------------------------|------------|--------------|---------|----------|--|--|
| | d. NAME OF HOSPIT | AL (If not in hospital, g | ive street o | | d. STREET ADDRESS e. 15 RESIDENCE | | | | | | | | |
| | OR INSTITUTION | eld_State_H | cenit | :e1 | 1516 Ridge Road ON A FARM | | | | | | | | |
| > | NAME OF | Fir | | | | | | | | | | | |
| > | DECEASED | _ | | Middle | Last | OF DEATH | July | ith | Do | • | Yeor | | |
| _ | (Type or print) | | rge | Augustus | Lowrey | والد | | 1959 | | | | | |
| 5. | SEX | | 7. MARRI | ED NEVER MARRIED | B. DATE OF BIRTH | | 9. AGE (In years lost birthday) | Months | Days | Hours | ER 24 HR | | |
| | Male | White | WIDOWE | trees . | November | 21,1879 | 79 yrs | | | | | | |
| I O | during most of work | N (Give kind of work of ling life, even if retired) | dane 10b l | KIND OF BUSINESS OR IND | USTRY 11. BIRTHPLACE | (State or foreign o | auntry) | 12. CIT | IZEN OF | WHAT | OUNTRY | | |
| | Shoe facto | | | - | Maryl | and | | | U.S. | A. | | | |
| 3. | FATHER'S NAME | | | | 14. MOTHER'S MAI | IDEN NAME | | | | | | | |
| | Alexander | Lowrey | | | Unkno | wm. | | | | | | | |
| IS. | . WAS DECEASED EVE | R IN U. S. ARMED FOR | | SOCIAL SECURITY NO. | INFORMANT | | Add | ress | | | | | |
| (Ye | es, no, or unknown) | (If yes, give war or dates of s | ervice) | - | Springfi | eld Hospi | tal Reco | rds | | | | | |
| - | | TH [Enter only one co | usa mas lia | a fee fee the sent to li | ob. 2.6.1 | 014 110bb | 1000 | 2 (4) | LINITE | RVAL 8E | TWEEN | | |
| | | TH WAS CAUSED BY: | | | | | | | ONS | ET AND | DEATH | | |
| | 170011111111111111111111111111111111111 | IMMEDIATE CAUSE (o | | <u>vrteriosclero</u> | tic cardiov | ascular c | ilsease. | | y | ars, | P | | |
| | 4221 | DUE TO | | | | | | | | | | | |
| | Conditions, if a | | | | | | | | | | | | |
| | gave rise to it couse (a), stoting | | | | | | | | | | | | |
| | lying cause lost. | le dittoir | 1 | | | | | | | | | | |
| ATION | Chronic T | er signif cant con Brain Syndr | ONE C | ONTRIBUTING TO DEATH & | osclerosis | and seni | CONDITION GIV | EN IN PAI | RT 1(o) 1 | | AUTOPS' | | |
| Ĭ | 20a ACCIDENT WA | S UNDERLYING [| 20b. DESC | RIBE HOW INJURY OCCUR | RED (Enter nature of inj | ury in Part I or Por | t It of item 18) | | | - | | | |
| CER | (IF EITHER, NOTIFY | CAUSE OF DEATH | | | | | | | | | | | |
| A | 20c. TIME OF INJUR | Y Month, Day, Yes | ac 20d IN | JURY OCCURRED 20e. | PLACE OF INJURY (Home | e form 20f (Cits | or lown) | - | County) | | (State | | |
| MEDIC | | , | While | Not while | octory, street, office bld | g., etc.) | , or rown, | , | Coomy | | (3.0) | | |
| Σ | | 19 | | of work | | | - | | | | | | |
| | 21. I certify th | at I attended the | decease | d from June 25. | | July 1, | 19.29 | that I lo | ast sav | the d | lecease | | |
| | alive an Ju | | _, 19_5 | 9 , and that dea | th accurred at 98 | 55A M, from | the causes an | d an th | e date | stated | d abav | | |
| | | -1 | ^ | | n | | treet, city or town, | | | | TE SIGNE | | |
| | ACTUAL SIGNATURE | Geistin | de | of Christ | Spring Spring | field Sta | ate Hospi | tal | | 1/1/ | 59 | | |
| | PHYSICIAN'S NAME (Type) | Agustin de | 1Camp | 00, M.D. (/ | Sykesv | ille, Man | ryland | | | | | | |
| 22 | O BURIAL, CREMAT O | N. 22b. DATE THEREC | F | 22c, NAME OF CEMETERY | OR CREMATORY | 22d. LOCA | TION (City town, | or county) | | (Stot | te) | | |
| | Burial | 17-3-59 | | Lorraine | Park (em. | Bal | timore, | Md. | | | | | |
| 13. | FUNERAL DIRECTOR | S SIGNATURE | | ADDRESS | 240 | REC'D BY REGIS | | STRAR'S SI | | | | | |
| 1 | eonard y | . Ruck 53 | 05 / | arford Rd. | DA | TE JUL 2 | '59 C | lithun . | 8. Ku | LLLA. | | | |
| | | | | - | | | | | | | | | |

TO HOSPITAL

VS A1S (4) 1SM 9/SB





7769 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY filed Maryland b. COUNTY Carroll MARYLAND uneral b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) þe RURAL ond give nearest town)
Wostminstor Westminster days P d NAME OF HOSPITAL (If not in hospital, give street address) d STREET ADDRESS OR INSTITUTION 101 Anchor 5t E. Green St. £... 4. DATE NAME OF Middle Month DECEASED July (Type or print) Reuther Mathias DEATH Nannie 9. AGE (In years 3 lost birthday) 86 yrs 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8 DATE OF BIRTH S SEX 16,187 February White Female DIVORCED [WIDOWED I 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) dod during most of working life, even if retired)
HOUSE WITE Own Home Carroll County. Md. carban 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Frederick Routher Margaret Wahlrath 0 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT Address Westminster, Md. Herbert G. Mathias no 18 CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] ā PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) JJ/ X **DUE TO** Conditions, if any, which gove rise to immediate **DUE TO** cotise (b), stoting the underlying couse lost PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY (1) 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 11 of item 18.) 20c. TIME OF INJURY Month. 20d. INJURY OCCURRED 20e. PLACE OF INJURY IHome, form, 20f. (City or town) Doy, Year foctory, street, office bldg., atc.) Hour o. m. Not while of work of work 122 Z, that I last saw the deceased 21. I certify that I attended the deceased from and that death occurred at 1.1369 M, from the causes and an the date stated above. ACTUAL SIGNATURE PHYSICIAN'S 878 W. Green St. Westminster, Md. Julius Chepko. M.D. NAME (Type) 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) 7-21-59 Leister Cemetery nr Westminster, Md.

> **ADDRESS** Westminster, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

117785

e. IS RESIDENCE

YES NO X

Year

1059

Rea. Dist. No.

Carroll

19

Days

(County)

24b. REGISTRAR'S SIGNATURE

Orilar S. Thous

24g. REC'D BY REGISTRAR

DATE JUL 2 2 '59

Months

IF UNDER 1 YEAR IF UNDER 24 HRS

Hours

INTERVAL BETWEEN

ONSET AND DEATH

PERFORMED?

(State)

YES NO ID

(Stote)

12. CITIZEN OF WHAT COUNTRY?

S

| Z I I C I | may be rela | TO FUNERAL | page 3 shar |
|-----------|-------------|------------|-------------|
| 1 | S . | A15 | (4) 'SS |

23. FUNERAL DIRECTOR'S SIGNATURE

John R. Byers



director

funeral

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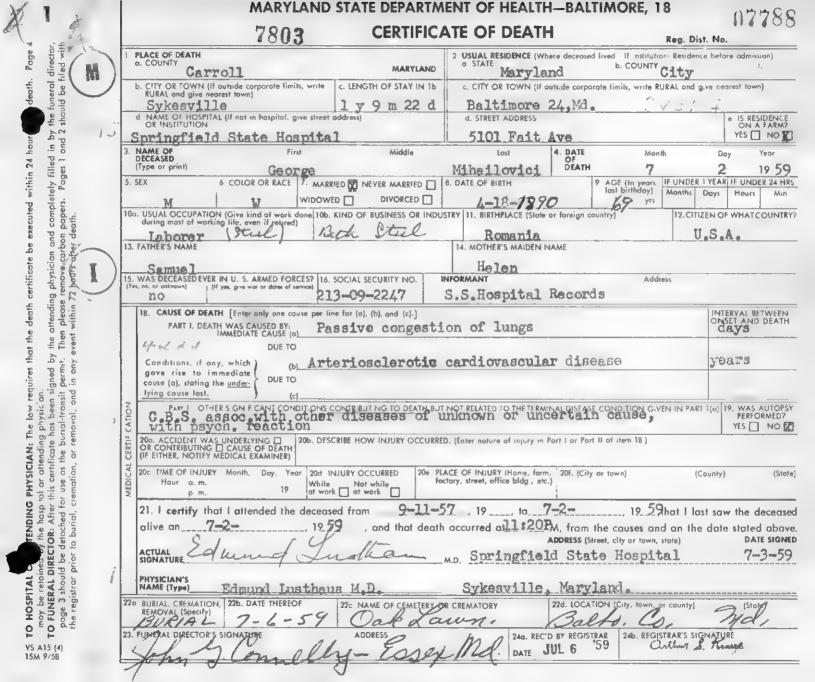
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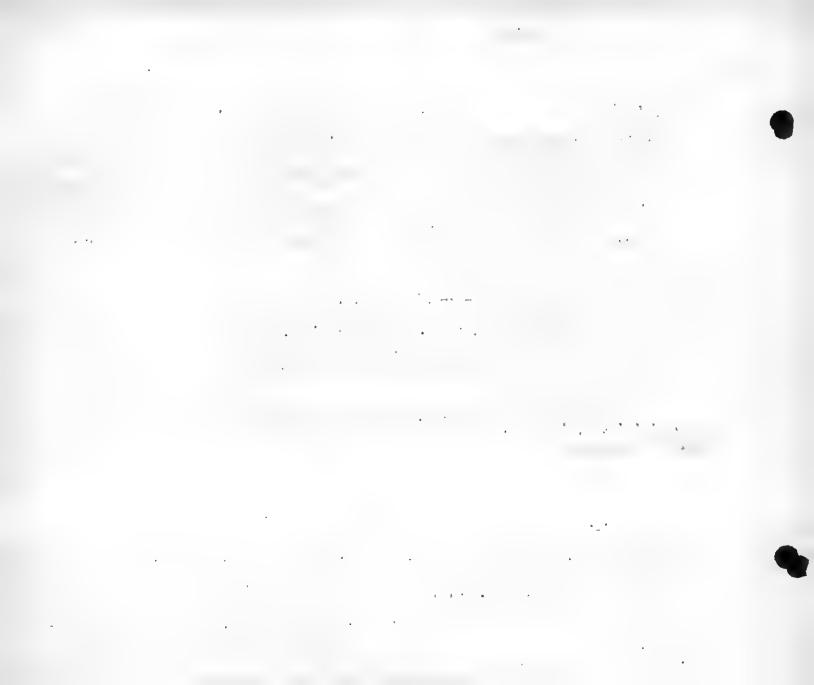
DIRECTOR:

FUNERAL

requires that the death certificate be







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physician

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TO FUNERAL DIRECTOR:

law requires that the deoth certificate be executed within 24 hour

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



death. Page

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FUNERAL DIRECTOR:

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **CERTIFICATE OF DEATH** 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived | (f institution: Residence before admission) a COUNTY o STATE filed **b** COUNTY MARYLAND b. CITY OR TOWN I I outside corporale limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give pearest town! shauld d STREET ADDRESS d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION NAME OF 4. DATE Middle Lost Month DECEASED (Type or print) DEATH 9 IAGE (In years/ IF UNDER 1 YEAR IF UNDER 24 HRS lost birthday) Magshs Days Haurs Min 6. COLOR OR RACE 7. MARRIED NEVER MARRIED TO 8. DATE OF BIRTH WIDOWED [** DIVORCED 10a USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (State or foreign country) during most of working life, even if retired) 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME WAS DECEASED EVER IN U. S. ARMED FORCES? INFORMANT Address 16. SOCIAL SECURITY NO. 18. CAUSE OF DEATH [Enter only one course per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) **DUE TO** Canditions, if any, which LLLINOMA gove tise to immediate DUE TO cause (a), stating the underlying couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, [Enter noture of injury in Part 1 or Port II of item 18) 20c. TIME OF INJURY Month, Day, Year 20e. PLACE OF INJURY (Hame, form, | 20f [City or town) 20d INJURY OCCURRED Not while factory, street, office bldg., etc.) Hour g. m. While al wark p. m. 19 57 that I last saw the deceased 21. I certify that J-attended the deceased fram death accurred at 6.76 A.M. fram the causes and an the date stated abave. alive an and that ADDRESS (Street, city or tawn, stole) ACTUAL SIGNATURE shauld PHYSICIAN'S NAME (Type) 22b. DATE THEREO BURIAL, CREMATION. 22c. NAME BEMOVAL (Specify

ADDRESS

V5 A15 (4) 15M 10/57 23. FUNERAL DIRECTOR'S SIGNATURE

240. REC'D'BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

3 '59 JUL 1

arthur & Krous

(County)

Reg. Dist. No.

e IS RESIDENCE ON A FARM?

YES TO NO 12

19

Hours

INTERVAL BETWEEN

ONSET AND DEATH

PERFORMED? YES 🗍 NO 🖺

(State)

(State)

12. CITIZÉN OF WHAT COUNTRY?



| | | | | AND STA | TE DEPARTM | ENT OF HEALTI | H—BALTIMOI | ₹E, 18 | 1 | |
|----|---------|---|--|---------------------|--------------------|---|---|------------------|---|--------|
| | | | 7807 | | CERTIFICA | ATE OF DEATI | Н | Reg. Di | ist. Ño. | |
| | 1 | PLACE OF DEATH | rroll | | MARYLAND | 2. USUAL RESIDENCE (WI o. STATE | _ b. C | DUNTY | nce before odmission) | = |
| | | | If outside corporate limi | | IGTH OF STAY IN 16 | c. CITY OR TOWN (IF | outside carporote limits, | - | | |
| | - | d. NAME OF HOSPIT OR INSTITUT ON | FAL (If not in hospital, g | ive street address) | | d. STREET ADDRESS | ATITE | | e. IS RESIDENCE ON A FARM? | _ |
| | - | | rield State | | | None | 1 | | YES NO | 8 |
| | | NAME OF DECEASED (Type or print) | Els | ie | Middle | Mullinix | 4. DATE OF DEATH | July | Day Year 2, 1959 | |
| | Ι. | ex Temale | 6. COLOR OR RACE White | 7. MARRIED WIDOWED | DIVORCED | B. DATE OF BIRTH | 9. AGE (In lost birt | | R 1 YEAR IF UNDER 24 HR Doys Hours Min | S |
| \ | | . USUAL OCCUPATION | ON (Give kind of work | done 10b, KIND O | F BUSINESS OR INDU | STRY 11. BIRTHPLACE (Stote | or foreign country) | | IZEN OF WHAT COUNTRY | Y? |
| | | FATHER'S NAME | king lite, even it retired | | - | Marylar | nd | | U.S.A. | _ |
| _/ | 1 | Henry Mu | llinix | | | Mary Da | _ | | | |
| | 15. | | R IN U. S. ARMED FOR | CES? 16 SOCIAL | SECURITY NO | NFORMANT | arel | Address | | - |
| | {Ya | No, or unknown) | (If yes, give war or dates of s | ervice) | _ | Springfield I | iosnital Re | cords | | |
| | | | ATH [Enter only one co ATH WAS CAUSED BY: IMMEDIATE CAUSE (o | A. A. | - | c heart dise | | | INTERVAL BETWEEN ONSET AND DEATH Years | |
| | | 420.0 | DUE TO | | | | | | | |
| | | Conditions, if o | | Gene | ralized ar | eriosclerosi | <u> </u> | | Years | |
| | | couse (a), stating lying cause last. | the under- | | | | | | | |
| | Z | | Correction of the | | | NOT RELATED TO THE TERM | | | | = Y |
| | CATION | Mental d | leficiency. | - Pulmor | nary tuber | mlosis, moder | rately adva | nced, act | ive PERFORMED? | ė |
| | CERTIF | 200. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY | AS UNDERLYING AS | 206 DESCRIBE H | OW INJURY OCCURRE | D. (Enter noture of injury in | Part I or Part II of item | 18 } | ' | |
| | MEDICAL | 20c. TIME OF INJUR Hour o. m. p. m. | Y Month, Day, Ye | | ot while fo | ACE OF INJURY (Home, fore ctory, street, office bldg., etc | | (| (County) (Stoke | e) |
| | | 21. I certify the | at I attended the | deceased fra | m Sept. 27 | 1955 , to J1 | | | ast saw the decease | |
| | | alive an_ | () | , 19_22 | _, and that death | accurred at 9: A | _M, fram the caus ADDRESS (Street, city o | | e date stated abave DATE SIGNE | |
| | | ACTUAL SIGNATURE | Uran Ka | dryk | weper | M.D. Springfie | old State H | | 7/2/59 | |
| | L | PHYSICIAN'S JU | lian Radcy | kowycz, l | M.D. | Sykesvil | le, Marylan | d | | |
| | 220 | BURIAL, CREMATIC REMOVAL (Specify) | | OF THE THE | mne Ti | my Brown | Ballin | town, or county) | (Stote) | |
| | 23. | FUNERAL DIRECTOR | 'S SIGNATURE | Al | DDRESS | 24g. REC | D BY REGISTRAR 24 | . REGISTRAR'S SI | IGNATURE | |
| | | from. | R H The | we P | elen rell | on of DATE (| 7.59 | | | |
| | | 1 | | 7 | | | | 1 2701910 | W/ | _ |

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| 1 | MAKYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 |
|--|--|
| * e= | 7808 CERTIFICATE OF DEATH Reg. Dist. No. 7997 |
| h. Page | 1. PLACE OF DEATH a. COUNTY CARROL 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE WARRAND b. COUNTY b. COUNTY c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest lown) |
| deat | b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest fown) C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |
| 24 haur illed in b es 1 and 2 | 3. NAME OF DECEASED (Type or print) ELSIE ALEMEDA MYERS 4. DATE OF DEATH JULY 15 19.59 |
| uted within mpletely f pers. Pog | 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH FEMALE WHITE WIDOWED DIVORCED JAN 11 1879 80 yrs. 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stole or foreign country) 12. CITIZEN OF WHAT COUNTRY? |
| an and co cacbon pa after death | HOUSE WIFE MARYLAND UNITED STAT 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 14. MOTHER'S MAIDEN NAME |
| og physici remove 72 haurs | CURTIS & BAKER LUUISA WERTZ FINES 15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT 17 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT 18 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT 18 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT 18 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT 19 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT 19 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT 19 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT 19 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT 19 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT 10 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT 10 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT 11 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT 12 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT 15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT 16 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT 17 WAS DECEASED EVER IN U. S. ARMED FORCES? 18 WERT NO. 18 WERT |
| t the death the attendir Then please vent within | 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION. DUE TO DUE TO |
| equires than, signed by t permit. d in any e | Conditions, if ony, which gave rise to immediate covise (a), staling the sunder- |
| The taw re 3 physician has been brial-transi maval, an | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED? YES \(\sigma \) NO III |
| SICIAN: attendin ertificate as the bi | 20a. ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f (City or town) (County) (State) |
| DING PHY raspital or After this c ed far use ict, cremal | Hour o. m. p. m. 19 While Not while of work of work 21. I certify that I attended the deceased from NOVE MBER. 1957, to JULY 15., 1959, that I last saw the deceased |
| TENT DIRECTOR: Id be detach prior to buri | alive and U.L.Y. 15, 1954, and that death occurred at S. A.M., from the causes and on the date stated above. ACTUAL SIGNATURE DELICIO DEL M.D. 19 Riccal Road 7-15-59 |
| SPITAL De reto IERAL J shou | PHYSICIAN'S D'ANIEL I WELLIVER Westminster Maryland 220. BURIAL CREMATION, 22% DAJE THEREOF 22c. NAME OF CEMETERY OF CREMATORY 22d LOCATION (CITY, 10WR, OF COUNTY) (Strole) |
| 5 5 == | REMOVAL, ISPECION, 1278 DATE THEREOF 220. NAME OF CEMETERY OR CREMATORY 220. LOCATION (City, Jown, or county) (Stole) 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE |
| VS A1S (4) 1SM 9/SS | Merwyn Comment of Date of 16:59 Colling & King |



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TO FUNERAL DIRECTOR:

VS A15 [4]

15M 9/58

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ENDING PHYSICIAN: The law requires that the death certificate be executed within 24.





VS A1S (4) 1SM 9/58

07796

| 1012 | CERTIFICATE OF BEATTI | | | Reg. Dist. No. | | | | |
|--|------------------------|--|---------------------|---|---------------------|----------------------|--|--|
| , PLACE OF DEATH | | 2, USUAL RESIDENCE (Wh | ere deceased live | d. If institution: Resi | dence before admiss | ion) | | |
| o. COUNTY Ca rroll | MARYLAND | o. STATE Maryla | nđ | b. COUNTY Mon | tgonery | | | |
| b CITY OR TOWN (If outside corporate limits, write c. LE) | IGTH OF STAY IN 16 | c. CITY OR TOWN (IF o | | | | 1) | | |
| RURAL ond give necrest town) Sykesville | lo m 7 day | s Bâthe | sda. Md. | / - | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address | | d. STREET ADDRESS | none nue | | e. IS RES | | | |
| Springfield Hospital | | 5915 Gloster | Rd Wood | acres | | NO P | | |
| NAME OF First DECEASED | Middle | Lost | 4. DATE | Month | Day | Year | | |
| (Type or print) Mary | Condie | Sanders | OF DEATH | 7 | 3 | 1959 | | |
| | NEVER MARRIED | B. DATE OF BIRTH | 9 At | | ER TYEAR IF UNDE | 1 | | |
| F W WIDOWED | DIVORCED | 4-27-89 | 7 | | S Days Hours | Min. | | |
| 0a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | OF BUSINESS OR INDUS | STRY 11. BIRTHPLACE (Stole | or foreign country | 12.0 | CITIZEN OF WHAT C | OUNTRY? | | |
| Housewife | | Utah | | | U.S.A. | | | |
| 3. FATHER'S NAME | | 14. MOTHER'S MAIDEN N | AME | 1 | | | | |
| Peter Condie | | Janet Wats | on | | | | | |
| S. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL Yes, no, or unknown) [18] yes, give wor or dates of service) | SECURITY NO. II | NFORMANT | | Address | | | | |
| | nem | S.S.Hospital | R. cords | | | | | |
| 18. CAUSE OF DEATH [Enter only one couse per line for (| | | | | INTERVAL BE | TWEEN | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (c) Brone | chooneumoni | 9 | | | ONSET AND | DEATH | | |
| 49/X DUE TO | -11 10 Part of 11 Part | | | | | | | |
| Conditions, if any, which) | | | | | | | | |
| gove rise to immediate | | | | | | | | |
| couse (o), stoling the <u>under-</u> lying couse lost. | | | | | | | | |
| PART II. OTHER SIGNIFICANT COND TIONS CONTRI | BUTING TO DEATH BUT | NOT RELATED TO THE TERMI | NAL DISEASE COL | DITION GIVEN JN F | ART 1(o) 19. WAS | AUTOPSY | | |
| Part II. OTHER SIGNIFICANT COND TIONS CONTRI- | | | | | PERFO YES 1 | RMED? | | |
| 200 ACCIDENT WAS UNDERLYING 1 206. DESCRIBE H | WINDS OF BRE | nchisotasis S. (Enter noture of injury in P | ort I or Port II of | item 18.) | 700 [_] | | | |
| OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | |
| 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY | OCCURRED 20e. PL | ACE OF INJURY (Home, form, | 20f (City or to | wn) | (County) | (Stote) | | |
| | of while for | tory, street, office bldg., etc. |) | | | | | |
| | 0.04 | 1957 to | 7_2_ | 10 501 | 1 | | | |
| 21. I certify that I oftended the deceased fro | | accurred at 2:30P | .(-,2- | , 19 <u>_5</u> 9that I | lost sow the d | eceosed | | |
| olive oil | _, and that death | | | causes ond an i city or town, stote) | | I obove. E signed | | |
| ACTUAL Today of Tugh | aan | Const on the | | | 7. | _3_50 | | |
| SIGNATURE COT TO STATE OF THE S | | w.b. <u>Springile</u> | Tr Space | HOSOTORY | | | | |
| PHYSICIAN'S NAME (Type) Edward Instinsiz M. | n | Sykesvill | e. Marvl | and. | | | | |
| And the same of th | NAME OF CEMETERY O | | | (City, town, or count | A (e | | | |
| BEMOVAL ISPE TO | | | | _ | | ej | | |
| | DDRESS | metery | Rocky: | 24b REGISTRAR'S | ry Land | | | |
| 13.3 . 4 13 | | rvland DATE JU | | C. Ilma | | | | |



07797

| | 7813 | | CERTIFICA | ATE OF D | EATH | | | Reg. Dist. N | 0. | V |
|--|--|------------------|---|-------------------------------|------------------------------|---|--|-----------------|--|------------|
| 1 PLACE OF DEATH | | | | 2 USUAL RESID | ENCE (Where | | | n: Residence be | fore admission) | |
| o. COUNTY | Carroll | | MARYLAND | o STATE | laryland | i t | COUNTY | City | | jer |
| b. CITY OR TOWN | (If outside corporate lim | nts, write | c. LENGTH OF STAY IN 16 | | | | nits, write RL | JRAL and give n | earest town) | |
| RURAL ond give Sykesvil | | | 23yrs.7mos.270 | avs B | altimor | ' @ | | 211. | | |
| | ITAL (If not in hospito), | give street | oddress) | d. STREET AL | | - | | | S RESIDEN | |
| | eld State F | | | 7 | 17 N. F | adera : | St. | | YES NO | |
| 3. NAME OF | | isi | Middle | Lost | | DATE | Mont | h 1 | Day Year | |
| (Type or print) | Rs | rbara | 1 | Scheiner | | OF DEATH | July | | 8. 195 | 'a |
| 5 SEX | | | | 8. DATE OF SIRTH | | 9. AG | E (In years | IF UNDER 1 YEA | | _# |
| Female | White | WIDOWE | | April 22 | | lost | birthdoy) 7 yrs. | Months Days | Hours I | Min, |
| | | | KIND OF BUSINESS OR INDU | | | reign country) | ,,,, | 12 CITIZEN | OF WHAT COUP | NTRY |
| during most of wo | rking life, even if relife | d) | | | | | | | | |
| 13. FATHER'S NAME | 10 | | - | 14. MOTHER'S | yland | | | . 0 | S.A. | |
| | Cumble. | | | | | | | | | |
| Joseph | ER IN U. S. ARMED FO | PCE(2) 14 | SOCIAL SECURITY NO | INFORMANT | a KLIM | 7 | Addr | A74 | | |
| (Yes, no, or unknown) | (If yes, give war or dates of | service) | | | 7.3 77 | 44.7 D | | | | |
| No | - | | | Springfie | Ta nost | n lear | ecoras | | | |
| | ATH [Enter only one c ATH WAS CAUSED 8Y: | | | | | | | O! | ITERVAL BETWE NSET AND DEA | ATH. |
| | IMMEDIATE CAUSE (| o) Ce | rebral hemorr | hage due | to hype | rtensi | OD | | Days | |
| 2217 | DUE TO | C | | | | | | | | |
| Conditions, if | | b] | | | | | | | | |
| gove rise to couse (o), stating | | 0 | | | | | | | | |
| lying couse lost | .) (| c): | | | | | | | | |
| Schizoph 200 ACCIDENT W OR CONTRIBUTION (IF EITHER, NOTIF | HER SIGNIFICANT CON | ion, | ONTRIBUTING TO DEATH BUT nebephrenic t | NOT RELATED TO | THE TERMINAL | DISEASE CON | DITION GIVI | EN IN PART 1(0) | 19 WAS AUTO PERFORME YES NO | OPSY D? |
| 20a ACCIDENT V | AS UNDERLYING C | 20b. DESC | RIBE HOW INJURY OCCURRE | D (Enter noture of | injury in Part | or Port II of | tem 18.) | | | |
| (IF EITHER, NOTIF | MEDICAL EXAMINER) | | | | | | | | | |
| 20c TIME OF INJL. | RY Month, Doy, Yo | eor 20d, II | NURY OCCURRED 206 PL | ACE OF INJURY (H | fome, farm, 2 | Of. (City or tov | (P) | (Count | y) (| Stote |
| Hour o.m. | | While | Not while to | ctory, street, office | bldg., etc.) | | | | | |
| A V III | 19 | of wor | c ot work | | | | | | | |
| | | | ot work C | 20 1051 | | 18 | ్య్రార్ల | | .1 . | |
| 21. I certify t | hat I attended the | | ed from October | 20, 1954 | toJuly | 18, | _, 1959, | that I last so | w the dece | ase |
| | hat I attended the | | | 20, 1954 accurred at | toJuly | fram the c | auses and | d on the da | te stated ab | oav |
| 21. I certify t | hat I attended the | | ed from October | accurred at | to July | fram the c | auses and ity or town, | d on the da | the dece te stated ab | oav |
| 21. I certify to alive an_Ju | hat I attended the | | ed from October | accurred at | toJuly | fram the c | auses and ity or town, | d on the da | te stated ab | oave |
| 21. I certify I alive an Ju | hat I attended the | decease | ed fram October | accurred at | to July | from the c RESS (Street, ci State | auses and ity or town, i Hospit | d on the da | te stated ab | oave |
| 21. I certify I alive an JU ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) | hat I attended the 1y 17. Edmund Lust ON. 1226 DATE THERE | decease Luchaus, | ed fram October | occurred at Spring Sykes | . 35A M. ADD agfield eville, | from the c RESS (Street, ci State | auses and ity or town, Hospit nd | d on the da | te stated ab | oave |
| 21. I certify to alive an | hat I attended the 1y 17. Edmund Lust ON. 1226 DATE THERE | decease Luchaus, | M.D. | M.D. Sprin Sykes | . 35A M. ADD agfield eville, | from the cores (Street, constant) State Maryla LOCATION (Constant) | auses and ity or town, Hospit nd | d on the do | te stated ab DATE SI 7/18/59 | oav |
| 21. I certify I alive anU ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) | Edmund Lust ON, 226 DATE THERE | decease Luchaus, | ed fram October 9 , and that death That | M.D. Sprin Sykes OR CREMATORY | . 35A M. ADD agfield eville, | from the c RESS (Street, c) State Maryla LOCATION (C) BALTIN: REGISTRAR | auses and ity or town, Hospit nd City, town, a | d on the da | te stated ab DATE SIGN 7/18/59 (State) | oave |





funerol should 24 9 Filled law requires that the death certificate be executed within completely puo physician attending p physician TO FUNERAL DIRECTOR: A page 3 shauld be detach

15M 9/58



07800

e. IS RESIDENCE ON A FARM?

Day

YES 🔲 NO 📆

Year

19 59 IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. 12 CITIZEN OF WHAT COUNTRY? U.S.A. INTERVAL BETWEEN ONSET AND DEATH years YES NO TO (Caunty) (State) 1959, to July 13 , 1959, that I last saw the deceased and that death accurred a 2:101 M, from the causes and an the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital Sykesville, Maryland 22d. LOCATION (City, town, or county) 22s. NAME OF CEMETERY OR CREMATORY (State) Baltimore, Maryland Vak Lawn (emetery 24g, REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE JUL 1 5 '59 Orthur S. Krous

page 0 VS A15 (4) 15M 9/58

220 BURIAL, CREMATION, 226 DATE THEREOF

27 FUNERAL DIRECTOR'S SIGNATURE

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Give

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 7817 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07802

Reg. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. COUNTY o. STATE b. COUNTY Carroll MARYLAND Baltimore Marvland b. CITY OR TOWN (If outside corporate limits, write RURAL c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) Reisterstown Near Taneytown d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS a. IS RESIDENCE ON A FARM? YES X NO Route #3 NAME OF First Middle 4. DATE Lost Month Day Yeor DECEASED OF (Type or print) 19 59 Berbers DEATH MARY SHEELE 12 July 5. SEX 9. AGE (In years 6. COLOR OR RACE 7- MARRIED NEVER MARRIED 1 8. DATE OF BIRTH IF UNDER TYEAR IF UNDER 24 HRS. lost birthday) Manths Days Hours Min White Female WIDOWED IT DIVORCED | 14th 1885 yra. 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (State or foreign country) during most af warking life, even if retired) 12. CITIZEN OF WHAT COUNTRY? House Wife Own home U.S.A Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME John D. Cramer Smith 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Reisterstown William C. Sheelev Ma Νo 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Multiple traumatic injuries IMMEDIATE CAUSE (a) **DUE TO** Conditions, if any, which gave rise to immediate cause **DUE TO** (o), stating the underlying cousa lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES | NO T 20g. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.) PRIMARY OF CONTRIBUTING CAUSE OF DEATH. Auto - Train collision. 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, i 20f. (City or town) (County) (Stote) factory, street, office bldg., etc.) Hour TOOK 195Q Railroad 1:50 p.m. of work of work Near Taneytown Carroll Md. 21. I certify that I took charge of the remains described above, held an Autopsy ... Inspection 30, Inquiry , and find that death resulted from: Natural causes ... Accident T Suicide . Homicide . Undetermined cause DATE SIGNED **ACTUAL** CHIEF MEDICAL EXAMINER SIGNATURE 7/13/59 ASSISTANT MEDICAL EXAMINER **EXAMINER'S** Charles S. Petty, M.D. NAME (Type) DEPUTY MEDICAL EXAMINER 220. BURIAL, CREMATION, 226. DATE THEREO 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (Stote) Glade Walkersville Md ADDRESS 23. FUNERAL DIRECTOR'S SIGNATURE 24g. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Circhary of France

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TO DEPUTY (CAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay essay, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral direction of the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a buriot-transit permit. File page 1 and 2 with the registrar prior to buriot, cremations

VS. A15ME(5) SM 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 7818 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | 1 | Reg. Dist. N | 0. |
|---|--|---------------|--|---------------------|-------------|------------------------|---|--------------|--------------------|
| 1. PLACE OF DEATH | | | | 18 | IDENCE (V | Vhere deceased live | | Residence b | efore admission) |
| | Carroll | | MARYLAND | o. STATE | Mar | yland | 6. COUNTY | Balti | more |
| b. CITY OR TOWN | (IT outside corporate limits, write rn) | RURAL | c. LENGTH OF STAY IN 16 | c. CITY OR | | autside corporate | | _ | neorest town) |
| | aneytown | | | | | sterstown | 0 | 3 x - | -1 |
| d NAME OF HOSPI | ITAL OF INSTITUTION (I | If not in hos | spital, give street address) | d. STREET | ADDRESS | | | | e. IS RESIDENCE |
| | | | | | Rou | te #3 | | | YES NO |
| 3, NAME OF DECEASED | Fin | st | Middle | Loss | | 4. DATE OF | Month | Da | y Year |
| (Type or print) | RAYM | | Н. | SHIDIN | | DEATH | July | | |
| 5. SEX | 1 | | | . DATE OF BIRTH | | lout | but below d | onths Doys | R IF UNDER 24 HRS. |
| Male | White | WIDOWE | | Oct, 10 | | | yrs. | | |
| during most of work | ing life, even if retired) | 1 | (IND OF BUSINESS OR INDUST | IRY 11. BIRTHPL | ACE (State | or foreign country |) | 12. CITIZEN | OF WHAT COUNTRY |
| Fart.e | r | 1 | Own farme | | Mary | Land | | U | .S.A |
| 13. FATHER'S NAME | | _ | • | 14. MOTHER'S | MAIDEN 1 | NAME | | | |
| | m Henery Sh | | | 1 | Gern | and | | | |
| 15. WAS DECEASED E (Yes, no, or unknown) | YER IN U. S. ARMED FOI (If you give wer or deten of | | | NFORMANT | | | Address | | |
| No | | | | William | C. 51 | reeley | Relat | erstow | n |
| | ATH [Enter only one cau | se per line | for (a), (b), and (c).] | | | | | INT | ERVAL BETWEEN |
| PART I. DE/ | ATH WAS CAUSED BY: IMMEDIATE CAUSE (6) | Mult | iple traumatic | injurie | 8 | | | | |
| × | DUE TO | | ** | | | | | | |
| Conditions, if | ony, which) (b) | | | | | | | | |
| gave rise to imme (a), stating the | ediate couse | | | | | | | | |
| couse last. | (c) | | | | | | | | |
| PART H. OT | HER SIGNIFICANT CON | DITIONS CO | ONTRIBUTING TO DEATH BUT I | NOT RELATED TO | THE TERM | INALDISEASE CON | DITION GIVEN | IN PART 1(o) | |
| PART H. OT | | | | | | | | | YES NO |
| 20g. EXTERNAL CA | USE WAS 20 | b. DESCRIBI | E HOW INJURY OCCURRED. (E | inter nature of in | jury in Por | t I ar Port II of iter | n 18.) | | |
| | | Au | to - Train col | lision. | | | | | |
| ZOC. TIME OF INJU | JRY Month, Day, Yea | r 20d. I | NJURY OCCURRED 200. PLA | CE OF INJURY (| lome, form | 20f. (City or to | en) | (County) | (State) |
| 2 J. 250 P. M. | 7/12 19 | 59 While | | ory, street, office | Didg., erc. | | nevtown | Car | roll Md. |
| | | ~ / | remains-described abo | | Autors | | | Inquiry [| l, and find that |
| | d from: Natural | - | ¬ (.) ¬ | | omicide | = ' | ermined cau | | g, and me |
| | 0/ | | | | QIII CCCC | , o oc. | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | »° Г. | |
| ACTUAL | 260.00 | 4 | Firm. | CHIFF M | HEDICAL EX | (AMINER | | | DATE SIGNED |
| SIGNATURE | - recei | 0 0 | The state of the s | m.M.D. | | AL EXAMINER | | | 7/13/59 |
| EXAMINER'S NAME (Type) | Chanles | Q D | ettv. M.D. | | | EXAMINER | | | 172777 |
| | ON, 226. DATE THEREO | | 22c. NAME OF CEMETERY OR | | | 22d. LOCATION | City town or c | cuply) | (State) |
| REMOVAL (Specify | 7/15/5 | | GLADE | U-SUMMER S | | | ersvill | | Md |
| 23. FUNERAL DIRECTO | 1-11 | | ADDRESS | | 24g. REC' | D BY REGISTRAR | 24b. REGISTR | | |
| 60 | 12 7 | _ | Walkersvill | • Md | DATE | | | 2 L. Krah | • |
| 7.11 | 1 DANO | Z. | | | DATE | | - Correw | 1 at, / Und | Am. |



| | AND STATE DEPARTMEN | NT OF HEALTH—BALTI! | MOKE, 18 0.38119 |
|--|---|--|---|
| 7819 | CERTIFICAT | E OF DEATH | Reg. Dist. No. |
| 1. PLACE OF DEATH a. COUNTY Carroll | MARYLAND 2. | usual residence (Where deceased live o. STATE Maryland | b. COUNTY Balto.City |
| b. CITY OR TOWN (If autside corporate limits RURAL and give nearest town) Sykesville | lyr.6mos.20days | CITY OR TOWN (If outside corporate Baltimore | limits, write RURAL and give nearest town) |
| d. NAME OF HOSPITAL (If not in hospitol, gir OR INST TUTION Springfield State Hos | re street oddress) | d. STREET ADDRESS 4205 Falls R | d Apt.17 e. IS RESIDENCE ON A FARM? YES \(\sqrt{1}\) NO \(\sqrt{5}\) |
| | ne Smith Stei | inmeier 4 DATE OF DEATH | Month Day Year July 29, 19 59 |
| Female White | WIDOWED DIVORCED | January 5, 1917 | AGE (In years IF UNDER 1 YEAR IF UNDER 24 HE ast birthday) Months Days Hours Min. |
| 10a JSLAL OCCUPATION (Give kind af work diduring most of working life, even if retired) Operator - PBX | - Bendix | Virg i nia | y) 12 CITIZEN OF WHAT COUNTR |
| 13. FATHER'S NAMEH. Charles Smith | | 4. MOTHER'S MAIDEN NAME Lillian Sincla | |
| 15. WAS DECEASED EVER IN J S. ARMED FORC (Yes, no, or unknown) (If yes, give wer or dates of ser | ES? 16 SOCIAL SECURITY NO INFO 213-03-5570 | RMANT Springfield Hosp | Address ital_Records |
| 18. CAUSE OF DEATH [Enter only one couper to the couper of | se per line for (o). (b), and (c).] Multiple scleros | sis | INTERVAL BETWEEN ONSET AND DEATH |
| Canditions, if any, which gove rise to immediate cause (a), stating the <u>under-lying</u> cause last. | | | |
| 200 ACCIDENT WAS JNDER YING OR CONTRIBUTING CAUSE OF DEATH U (IF EITHER, NOTIFY MEDICAL EXAMINER) | TONS CONTRIBUTING TO DEATH BUT NO TACTURE, LETT FEMOUR CRUSE WITH DSYCHOTI OB DESCRIBE HOW INJURY OF CURRED (E | of RELATED TO THE TERMINAL D SEASE CO. — C.B.S. 2850C. wit C reaction. Enter nature of injury in Port 1 or Port 11 or | DIDITION G.YEN IN PART 1(0) 19. WAS AUTOPS PERFORMED? YES NO |
| ZOc. TIME OF INJURY Manth, Day, Year Haur o m. | 20d INJURY OCCURRED 20e PLACE While Not while factory of wark | OF INJURY (Home, Farm, 20f (City or street affice bldg , etc.) | rawn) (County) (Stat |
| alive an July 28, | , 19 59 , and that death ac | coursed at 7110AM, from the | causes and an the date stated above city or town, store) DATE SIGNI |
| ACTUAL SIGNATURE PHYSICIAN'S FEDWARD True | Luothans M.D. | Springfield State | e Hospital 7/29/59 |
| 22a. BURIAL, CREMATION, 22b. DATE THEREOF | | Sykesville, Md. | I (City, tawn, or county) (State) |
| REMOVAL (Specify) | 220 Family Of Control Of Co | | |
| Burial Aug 1, 1 23. FUNERAL DIRECTOR'S SIGNATURE | 959 Loudon Park Address | 240. REC'D BY REGISTRAR DATE JUL 3 0 '59 | more Maryland 24b REGISTRAR'S SIGNATURE |

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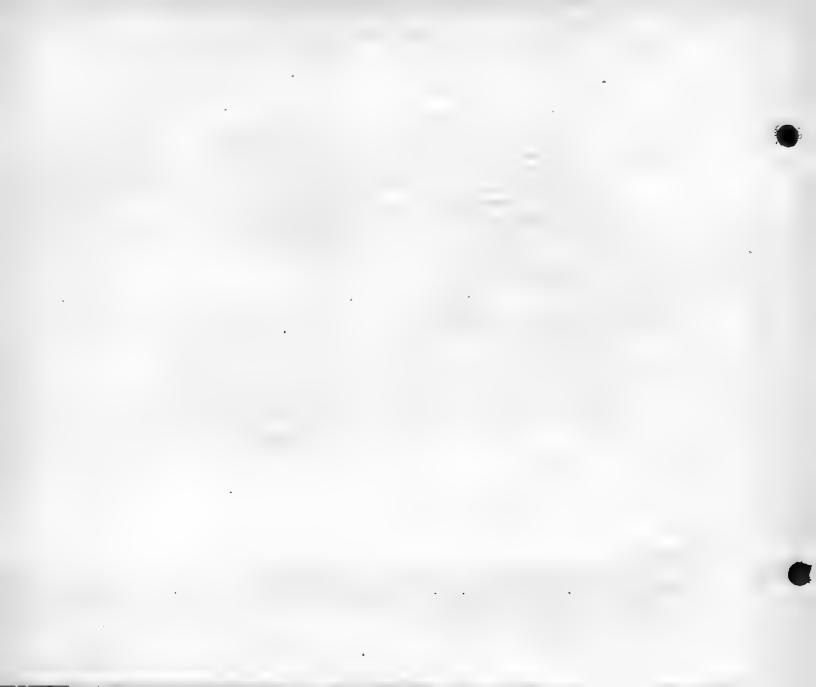
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7820

CERTIFICATE OF DEATH

| L | | | | | Keg. Dist. No. | | |
|---|---|---|--------------------------------------|--|--|--|--|
| Ī | PLACE OF DEATH O. COUNTY Carroll | MARYLAND | 2 USUAL RESIDENCE (Who o. STATE M.C. | ere deceased lived If institution b COUNTY | Residence before admission) Carroll | | |
| | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville R.D.L | c. LENGTH OF STAY IN 16 | | utside corporate limits, write RUR | tAL and give nearest lown) | | |
| | or institution Oakland Road | | d. STREET ADDRESS Oakland | Road | e. IS RESIDENCE ON A FARM? YES NO 🔀 | | |
| 3 | NAME OF DECEASED (Type or print) Annie A | lverta T | eal | 4. DATE Month OF July 2 | 9,1959 Year | | |
| | SEX 6. COLOR OF RACE 7. MARK | | July 25,188 | | Months Days Hours Min | | |
| Ti | Od. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSCWOPK | KIND OF BUSINESS OR INDUS | Maryland | | 12 CITIZEN OF WHAT COUNTRY | | |
| i: | 3. FATHER'S NAME | | 14. MOTHER'S MAIDEN N | AME | - X | | |
| L | Richard W.Allender | | Florence | V.Eckman | | | |
| U | 5 WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no or unknown) (If yes, give wor or dotes of service) NO | SOCIAL SECURITY NO. 17. III 15-32-0717 M | | rothers, Syke | | | |
| | Conditions, if ony, which gove rise to immediate couse (a), stating the under-lying couse last. | Arteriosclero | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| COTICICATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II 200. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH IIF EITHER, NOTIFY MEDICAL EXAMINERY OR TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II | | | | | | |
| TO PE THER. NOTIFY MEDICAL EXAMINED ON PLACE OF INJURY (Home, form., Post of the post of work | | | | | | | |
| | | ed from 1-26-44 and that death | accurred at 1 P | M, from the causes and ADDRESS (Street, city or town, start Road | that I lost saw the deceased on the date stated above the parts signed 7-30-59 | | |
| 2 | 20. BURIAL CREMATION 22b. DATE THEREOF BURIAL (Specify) Burial Aug. 1, 1959 | 22c NAME OF CEMETERY OF All-Saints | CREMATORY | 22d LOCATION (City, fown, or Reisterston | | | |
| 23 | J.F. Eline & Sons, Re | ADDRESS | | 8Y REGISTRAR 246. REGISTR | PAR'S SIGNATURE | | |



07806**CERTIFICATE OF DEATH** Rea. Dist. Na PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY filed **L COUNTY** MARYLAND b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR JOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town? d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? YES | NO 1 NAME OF First Middle 4. DATE Month Day Year DECEASED OF DEATH (Type or print) 19 5. SEX 6. COLOR OF RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH AGE (InTypors IF UNDER 1 YEAR IF UNDER 24 HRS lost birthday) Months Doys Hours WIDOWED I DIVORCED popers. 10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY during most of working life; even if retired) 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 200 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT Address [H yes, give wor or dates of service) CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave rise to immediate **DUE TO** couse (o), stoting the underlying couse lost. PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(q) 19. WAS AUTOPSY PERFORMED? YES NO 200. ACCIDENT WAS UNDERLYING OF CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c, TIME OF INJURY Month. Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) Hour a. m. While factory, street, office bldg., etc.) Not while p. m. of work at work 21. I certify that l'attended the deceased from 19 \$ Z . that I last saw the deceased alive an and that death accurred at 12.40 2M, from the causes and on the date stated above. ADDRESS (Street, city or fown, state) ACTUAL SIGNATURE P shaul PHYSICIAN'S NAME (Type) 220 BURIAL, CREMATION. 22b. DATE THEREO! 22c NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) REMOVAL (Specify) 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 24g. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE VS A15 (4) 15M 9/55 DATESUL Chr. a & France

YLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



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FUNERAL DIRECTOR:

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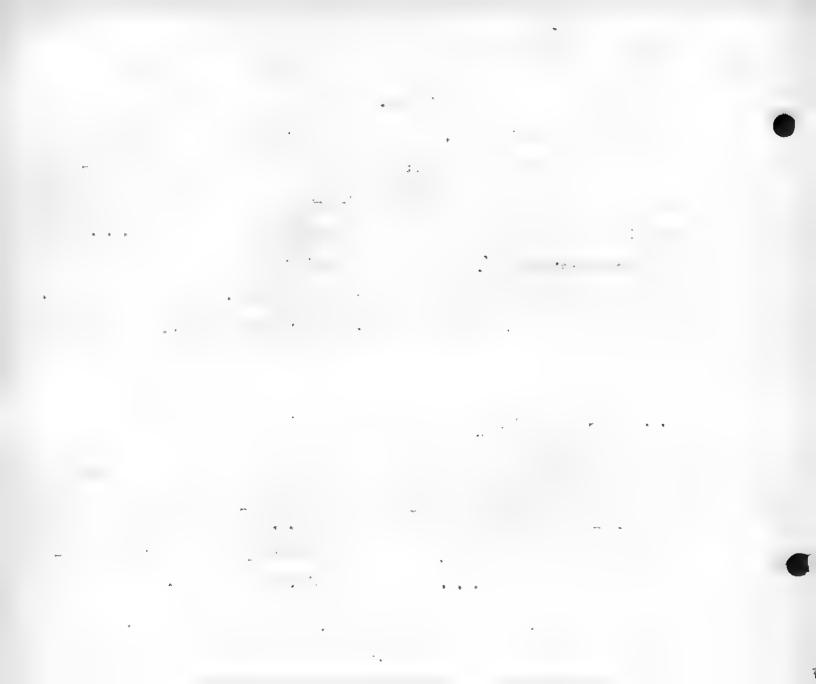
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law requires that the death certificate be executed within 24 hour



| | | MARYLAND STATE DEPARTM | MENT OF HEALTH—BALTIM | ORE, 18 (1781) |
|----|----------|---|---|--|
| | | 7824 CERTIFIC | ATE OF DEATH | Reg. Dist. No. |
| M) | 1. 1 | PLACE OF DEATH COUNTY MARYLAND | 2. USUAL RESIDENCE (Where deceased lived o. STATE Marvland | I. If institution: Residence before admission) b. COUNTY Baltimore |
| | | b. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) | c. CITY OR TOWN (If outside corporate li | |
| | _ | Sykestille 32v/m 2/ day | d. STREET ADDRESS | IS RESIDENCE ON A FARM? |
| | 1 | Springfield State Hospital | | YES NO |
| | | NAME OF First Middle DECEASED Type or print) Blanche | Upton 4 DATE OF DEATH | Month Day Year 7 3 19 59 |
| | 5. 5 | 6. COLOR OR RACE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED | 8 DATE OF BIRTH 9. AC los | GE (In years IF UNDER 1 YEAR IF UNDER 24 HRS to birthday) Months Days Hours Min. |
| | 10a | . USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR IND | | 9.3 |
| | 13. | during most of working life, even if relired) 1ahorer FATHER'S NAME | Maryland 14. MOTHER'S MAIDEN NAME | U.S.A. |
| | | Tohn IInton | Agnes Cavey | |
| | 15. | AS DECEASEDEVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO no, or unknown) 1 (if yes, give wer or dates of service) | INFORMANT | Address |
| | (10) | (if yes, give war or gords or service) | S.S. Hospital Records | |
| | | 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH |
| | 1 | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) Bronchopneumon | la | days |
| | V | 11 G / Y DUE TO | | |
| | | Conditions, if any, which (b) | | |
| | | couse (o), stoting the under- | | |
| | Z | lying cause last. (c) (c) Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT | T NOT RELATED TO THE TERMINAL DISEASE CON | NDITION GIVEN IN PART I(a) 19 WAS AUTOPSY |
| 3 | FICATION | Part II OTHER SIGNIFICANT CONDITIONS CONTRIBLTING TO DEATH BUT Mental deficiency, undalescentiated, | Heat prostration | PERFORMED? YES NO IC |
| | FIC | 200 ACC DENT WAS UNDERLYING [] 206. DESCRIBE HOW INJURY OCCURR | ED (Enter nature of miury in Port 1 or Port 1) of | |
| | CERT | 20g ACC DENT WAS UNDERLYING [] 20b. DESCRIBE HOW INJURY OCCURE OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | |
| | MEDICAL | | LACE OF INJURY (Home, form, 20f (City or to | wn) (County) (Slote) |
| | MEC | Hour o. m. p. m. 19 While Not while of work of work | Salary, and steel, state, | |
| | | 21. I certify that I attended the deceased from 10-20 | 19. 54, to | _, 1959 ,that I last saw the deceased |
| | | alive on 7-3- , 1959, and that deal | | causes and an the date stated abave |
| | | ACTUAL Gland Gerollia | ADDRESS (Street, | |
| 4 | | SIGNATURE CA COLOR | Mb Springfield Stat | e Hospital 7-4-59 |
| | | PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D. | Sykesville, Mary | land. |
| | 220 | BURIAL, CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY | OR CREMATORY 22d. LOCATION | (City, town, or county) (Stote) |
| | 1 | Quial July 7, 1959 ST. John | CEMETERY ELLICO | TO CITY Md. |
| 1 | -4 | | | |
| 0 | 23. | FUNERAL DIRECTOR'S SIGNATURE ADDRESS | Z4g. REC'D BY REGISTRAR DATE JUL 7 59 | 246 REGISTRAR'S SIGNATURE Chilmy & Krand |

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by low requires that the death certificate be executed within 24 haurs puo 2. completely filled puo P mave carbo offer physician offending ATTENDING detached may be retained by the TO FUNERAL DIRECTOR: should be registror abod VS A15 (4) 15M 9/58

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1 23° A.A. :1: · Turning . The second

in by the funeral director, and 2 should be filed with Her death, Page 4 TO HOSPITAL ATTENDING PHYSICIAN: The low regultes that the death certificate be executed within 24 hour may be retained by the hospital or attending physician.

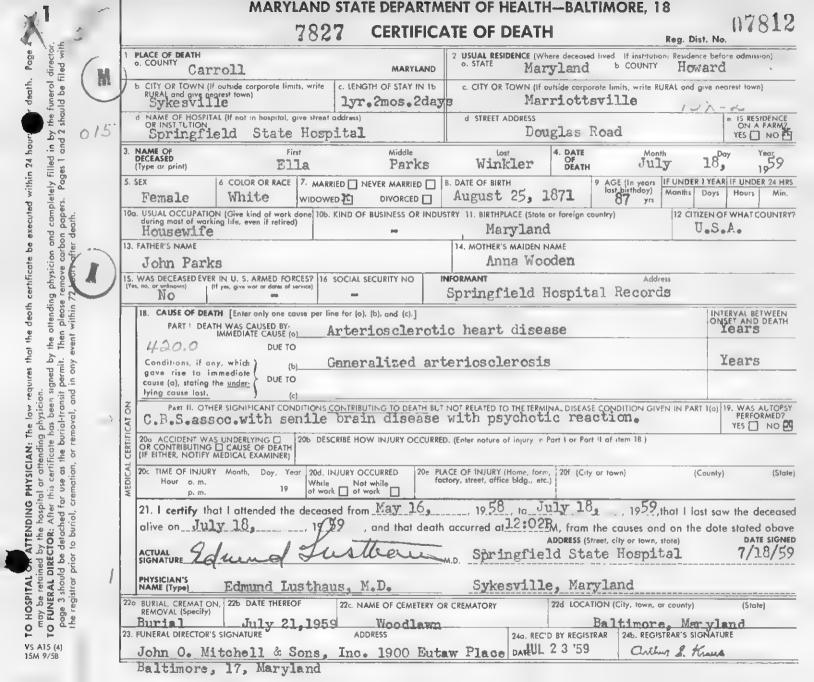
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in b page 3 shauld be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and the registrar prior to burial, crematian, or removal, and in any event within 72 hours after death.

> VS A15 (4) 15M 9/55

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| | MARYLAND STA | ATE DEPARTM | ENT OF HEALTH- | -BALTIMORE, 1 | 8 |
|---------------|--|--|---|--|---|
| | 7826 | CERTIFICA | TE OF DEATH | | Reg. Dist, No. |
| 1. [| COUNTY Carroll | MARYLAND | 2 USUAL RESIDENCE (When | e deceased lived. If institution b. COUNTY | on Residence before admission) |
| | RURAL and give neorest town) (Lineboyo R 3. | ength of stay in 16 45 yrs. | city or town (if our | Side corporale limits, write RI | JRAL and give nearest town) |
| | d NAME OF HOSPITAL (If not in hospital, give street addres OR INSTITUTION | is) V | d. STREET ADDRESS | R.D. | e. IS RESIDENCE ON A FARM? YES NO |
| | NAME OF DECEASED (Type or print) GEORGE | BAUGHE! | ~ 1 / | 4. DATE OF DEATH OF DEATH | 1 3 1959 |
| 5. | Male White WIDOWED WIDOWED | NEVER MARRIED | 6. DATE OF BIRTH 4/17/188 | 9. ASK (In years last birthdoy) 73 yes. | Months Doys Hours Min |
| 10a | USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | OF BUSINESS OR INDUS | Gork | Co. Oa | 12. CITIZEN OF WHAT COUNTRY? |
| | FATHER'S NAME Sohn &. We | Com | amilea | Bougho | 1 |
| 15. | the or unknown) (if yes, give war or dates at service) 2/8- | -32-3590 × | Cenny 17 4 | V erner | Lineboro 24 |
| | 18. CAUSE OF DEATH [Enter only one couse per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o). | (a), (b), ond (c) } | Zhuon | bour | INTERVAL BETWEEN ONSET AND DEATH |
| | Conditions, if any, which gove rise to immediate couse (a), stating the under- | terrosil | lenotic /fe | and Dere | me 5 yr |
| CERTIFICATION | PART II OTHER SIGNIFICANT CONDITIONS CONTE | RIBUTING TO DEATH BUT | NOT RELATED TO THE TERMIN | AL DISEASE CONDITION GIV | EN IN PART 1(a) 19, WAS AUTOPSY PERFORMED? YES NO |
| CERTIF | 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | HOW INJURY OCCURRED | D (Enter noture of injury in Pa | rt I ar Parl II of item 18.) | |
| MEDICAL | Hour o. m. While | Y OCCURRED 20e PL/ Not white of work | ACE OF INJURY (Home, farm, story, street, office bldg., etc.) | 20f (Cily or lown) | (County) (State) |
| | 21. I certify that I attended the deceased for alive an 1959 ACTUAL TO CAN PHYSICIAN'S NAME (Type) | om Recommend and that death | | 1 | that I last saw the deceased and an the date stated abave. pate signed |
| | Burrelly July 6, 1959 | Black Rocl | R CREMATORY (2) | Vine vors M.D. | Chuthe Co. (State) |
| 23. | FUNERAC DIRECTORS, SIGNATURE | n Rock | Ja. DATE JU | tro . | Littur S. Kenus |





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| 1 | | MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 |
|--|----------|--|
| + 3E | | 7829 CERTIFICATE OF DEATH Reg. Dist. No. 17813 |
| director filled with | 1 | PLACE OF DEATH COUNTY O STATE MARYLAND 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. COUNTY D. COU |
| funeral fund be f | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown) RURAL and give referest town 28 cays Baltimal, Maylund |
| in by the | | d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ON A FARM? YES NOW NOW NOW NOW NOW NOW NOW NOW |
| 24 | | NAME OF DECEASED (Type or print) Mary Gorfrude Winstantey Death July 7 1959 |
| Pogot Pogot | 5 | Female While WIDOWED DIVORCED Quest 27, 1886 172 yrs Months Doys Hours Min. |
| and can | | USUAL OCCUPATION Give kind of work done during most of working life, even if retired) HOUSE USIFE HOUSE AND HOUSENSS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) HOUSE USIFE HOUSE AND HOUSENSS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) HOUSE USIFE HOUSENSS OF WHAT COUNTRY? |
| sician ve cark rrs afte | | James McCormick Margaret - |
| th certifi ding phy se remo n 72 hou | (Yu | no or unknown, Ill yes give war or dates of service None James Kirrear - 5221 Garmouth Rd. |
| he dea e attence en plea nt withi | | 18. CAUSE OF DEATH [Enter only one couse per line too)(a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE OFORWAY OCCUSION UNDERTONNEY. |
| quires that t signed by th permit. Th d in any eve | | Conditions, if ony, which gave rise to immediate cause (o), stating the under lying cause last. DUE TO OUE TO |
| he faw re physician nas been rial-transi naval, an | CATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? YES \[\Box\ NO'\frac{15\pi}{200}\] |
| tending ifficate iffe bu | L CERTIF | 20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| PHYSK hall ar all this cert ir use as remation | MEDICAL | 20c TIME OF INJURY Month, Day, Year Hour a.m. p. m. 19 20d. INJURY OCCURRED While of work at wark a |
| TTENDING J by the hospil ECTOR: After be detached for ar to burial, ar | | 21. I certify that I attended the deceased from Jurce 9, 1959, to July 7, 1959, that I last saw the deceased alive an July 3, 1959, and that death accurred at 7/1/4 M, from the causes and an the date stated above ADDRESS (Street, city or town, state) ACTUAL SIGNATURE SIGNATURE M. D. Handsland May Course 7/7/54 |
| retaines RAL DIR should I strar pri | | PHYSICIAN'S Sosepol E. Bush MID HAMPSTEAD Mary land. |
| O HOSP may be page 3 page 3 the regi | | Burial CREMATION 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town for county) (Stole) REMOVAL (Specify) 7/210/59 Woodlawn Cem. Woodlawn, Md. |
| VS A1S (4) 15M 10/57 | 23. | SUNDAL J. W. RULL SOUN - WILL DATE; JUL 9 '59 SIGNATURE ADDRESS |



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

death. Page

requires that the death certificate be executed within 24

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



FOR STATE HEALTH DEPT

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or removel, and in any event

or its designated agent, prior to burial,

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 7831

07816

Rea. Dist. No.

| and the ball to see the ball of the ball o | The state of the s | AND WASHINGTON TO SHARE THE PARTY OF THE PAR | | | | | THE RESERVE TO THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TW | The state of the last | and the same of th | | |
|--|--|--|----------------------------|---------------|---|------------------------|--|-----------------------|--|------------|---|
| 1. PLACE OF DEATH | Carroll | | MARY | LAND | 2. USUAL RESIDENCE (V | where decess | ed lived. If institu | | dence be | | nission) |
| and give nearest town | l'eutride corporate limits, write l' Westminste | | 7yrs. | N 16 | X Rural. | | corole limils, write | | nd give r | neorest to | own) |
| | AL OR INSTITUTION (IN | | pital, give street address | ž. | / d. STREET ADDRESS | Taylo: | rsville | | | ON | RESIDENCE I A FARM? |
| 3. NAME OF DECEASED (Type or print) | ALLEN | | Middle THURMAN | WR | IGHT | 4. DATE OF DEATH | Month | | Doy 16 | | Year 1959 |
| s. sex male | 6. COLOR OR RACE | 7. MARRIE | D DIVORCED | | 0416 OF BIRTH | 8 | 9, AGE (In years fast birthday) 70 yrs. | Months | Days | Hours | Min. |
| | ON (Give kind of work d | one 10b, K | OWN | NDUSTRY | After the same of | or foreign o | ountry) | 12. C | U. | | COUNTRYS |
| 13. FATHER'S NAME | George | A. V | Vright | | Mary (| NAME Glass | | | | | |
| 15. WAS DECEASED EV | ER IN U. S. ARMED FOR (If yes, give wer or doles of s | ervice) | SOCIAL SECURITY NO. | | ormant s. Margie | H. W | Address right, | | ame | | |
| Conditions, if a gove rise to imme (o), stoling the couse last. PART II, OTI | diote couse | DITIONS CO | ONTRIBUTING TO DEATH | I BUT NO | OT RELATED TO THE TERM | IINAL DISEASI | E CONDITION GIV | YEN IN PA | | PERF | AUTOPSY |
| PART II. OT | | Seef 204. | | e. PLACE | OF INJURY (Home, formy, street, office bldg., etc. | m, 20f.4Cily | | R6-10 | iounty) | YES [] | (State) |
| 21. I certify t | hat I taak charge resulted from: N | af the i | remains described | Total Control | e, held an Autaps | Hamicide | | Inquermined | mann | er 🔲 | od in my |
| EXAMINER'S NAME (Type) 220- BURIAL, CREMATIC | JAMES | T | 7 MARS 7 | RY OR C | DEPUTY MEDICAL | EXAMINER | 7 | or county |) | (Sto | 159 |
| BURIAL | 7-19-19 | | Taylors | | le le | Carr | oll Co. | ,Md. | | | 300000000000000000000000000000000000000 |
| C. M. W | | Winf: | ield, Md. | | 240. REC | IL 21 5 | 9 CA | STRAR'S S | - 0 - | | |

TO DEPUTY CAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay in issay, please execute the certificate, writing the ward "pending" in pencil in Item, 18. Give Pages 1, 2, and 3 to the function. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained tor your files. The FUNEX DIRECTOR: Page 3 should be used as a buriot-transit permit. File Tages 3 and 2 with the State Board of Health, or its designated agent, prior to buriad, cremation, or removal, and in any eyent within 72 hours after death. VS AISME 5M 2/57

TOST PURSUENT SYMMET LESS TO STUDIO TO STUDIO DE LA PROPERTI I DE LA PROPERTITION DE LA PROPERTI ION DEPUTA DE LA PROPERTITION DEPUTA DE LA PROPERTITION DE LA PROPERTITION DEPUTA DE LA PROPERTITION DE LA PROPERTITION 4 0

